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

November 17, 2015

Acting Administrator Andy Slavitt
Centers for Medicare & Medicaid Services
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)

Dear Acting Administrator Slavitt,

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

We applaud CMS for its continued commitment to shifting to value-based payment and moving away from payment models that reward volume rather than quality and value. The implementation of the Medicare Access and CHIP Reauthorization Act (MACRA) is a critical opportunity to strengthen the delivery of care for Medicare beneficiaries, and we welcome the opportunity to offer initial comments on the regulatory framework. Specifically, we offer comments on improved quality measurement, support for transformed clinical practices that are oriented towards the Triple Aim, robust use of electronic health information exchange across all evaluation categories for the Merit-Based Incentive Payment System and for eligible Alternative Payment Models, criteria for truly patient-centered medical homes, and key principles for ensuring that eligible APMs are providing authentic patient- and family-centered care.

If you have any questions about our comments and recommendations, please contact Lauren Birchfield Kennedy, Director of Health Policy, at lkennedy@nationalpartnership.org or (202) 986-2600.

Sincerely,

Debra L. Ness, President

A. THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

1. **With regards to quality measurement, providers must be accountable to patients, first and foremost, and quality measurement should reflect this principle. The National Partnership supports the use of patient experience measures and patient reported outcome measures (PROMs) in the MIPS quality measure set. PROMs should include measures of functional status and quality of life. These kinds of high impact quality measures, which are meaningful to both consumers and providers, will help providers drive quality improvement and value. Significant priority should be given to improving and expanding use of patient experience and PROMs. Emphasis should be placed on measures that can be collected as part of clinical workflow and that can provide timely and actionable feedback for improvement.**

The majority of measures in the MIPS quality measure set should be outcomes-based, including patient-reported outcomes measures (PROMs), patient experience measures, process measures that are linked to outcomes, and cross-cutting measures.[1] Measures of processes 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. As new measures are developed and added to the MIPS set, all new measures should go through a multi-stakeholder review process to ensure they are evidence-based and meet the needs of all stakeholders, including consumers and purchasers. Over time, we hope to see evolution toward better measures and measurement systems, including:

- Improved outcome measures and measures based on patient-reported data,
- Measures suitable for assessing new delivery and payment models without detracting from clinician-level information,
- Measures that can be collected efficiently in the course of clinician-patient workflow, particularly those that utilize electronic data capture, and
- Measures that provide real-time, actionable data for various stakeholders.

Patient Reported Outcome Measures and Patient Experience Measures

In response to Question 3.a., we specifically urge 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 consumers and providers, and should help drive quality improvement and value. Clinical outcome measures alone, for example, provide an incomplete picture of quality, since they do not capture the patient's perspective or personal

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[1] For brevity, we refer throughout our comments to "patient" and "care," given that many federal programs and initiatives are rooted in the medical model. To some, these terms could imply a focus on episodes of illness and exclusive dependency on professionals. Any effort to improve patient and family engagement must include the use of terminology that also resonates with the numerous consumer perspectives not adequately reflected by medical model terminology. For example, people with disabilities frequently refer to themselves as "consumers" or merely "persons" (rather than patients). Similarly, the health care community uses the terminology "caregivers" and "care plans," while the independent living movement may refer to "peer support" and "integrated person-centered planning."

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. And, public reporting of patient-reported outcomes measures makes this type of quality performance information accessible and useful to patients.

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 urge CMS to go beyond the "core" CAHPS survey, however, and consider questions – including supplemental item set questions – that reflect areas of significant importance to patients and families. For example, the Cultural Competence supplemental item set includes questions assessing:

- Whether a provider spoke too fast or used words a patient didn't understand;
- Whether the patient felt they were treated unfairly because of their race, ethnicity, or how well they spoke English; and
- If necessary, whether an interpreter was provided, and how they would rate the interpreter.

The health information technology (HIT) supplemental item set includes questions such as:

- Whether patients are able to email their provider with questions, and get responses back in a timely fashion; and
- Whether the provider's office puts laboratory or other test results on a website for the patient to see, and how easy it was to find those results.

We also support continuing research and implementation efforts to combine patient experience survey scores with narrative questions. Integrating more open-ended questions will allow for beneficiaries/patients to share nuanced and rich information that will make patient experience surveys more meaningful for quality improvement. For example, when a patient indicates that her provider is not communicating with her in ways she understands, she could also describe why – for example, perhaps the provider is using a great deal of technical jargon or the practice fails to provide for an interpreter when needed.

Finally, as discussed below in response to the RFI's provisions on Clinical Practice Improvement Activities aimed at enhancing beneficiary engagement, we note that partnering with patients and families via Patient and Family Advisory Councils can also enhance a practice's understanding of patient and family experience. PFACs can help to identify why a practice may be having challenges within a particular patient experience domain, but also go beyond to support the collaborative development of solutions to improve experience.

Data Stratification and Health Disparities

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

The use of Certified Electronic Health Record (EHR) technology (CEHRT), for example, gives providers the ability to stratify quality measures: the final 2015 Edition certification criteria will 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 strongly recommend that data also be reported based on *sexual orientation* and *gender identity*, and *functional and cognitive status*, in addition to race, ethnicity, and gender.

We encourage CMS to require public reporting of stratified quality data at both individual and practice levels. Doing so will report trends in health equity that aid consumers in making informed choices, in addition to aiding providers in identifying and ultimately reducing health disparities. Because of the potentially confusing nature of reporting stratified data, we strongly urge CMS to do consumer testing on the language that would accompany public reporting on stratified data and health disparities.

Additionally, we support including improvements in health equity and reductions in health disparities as part of the definition of improvement with respect to measures and activities for the MIPS performance categories.

Feedback Reports

We encourage CMS to require real-time feedback reports on practice performance so that practices can deploy quality improvement strategies as needed, particularly in high-impact areas like patient experience of care. We believe that feedback reports will be most effective if they reflect individual provider performance. To the extent possible, providing data on clinical performance at an even more granular patient level is most useful in identifying where gaps, variation, or duplication may exist, and provides the most actionable information to target improvement efforts.

Further, we believe it would be immensely helpful for Eligible Providers (EPs) to receive feedback related to their performance on the meaningful use of CEHRT category. CMS should offer EPs a transparent view into their performance to enable them to appropriately evaluate efforts to date and areas for growth. For example, a population health dashboard to enable EPs to see, at a glance, their performance on a suite of quality measures across a given patient population could help providers quickly check how they are doing at any point in time. Furthermore, we believe that this information should be available upon provider request (by demand). We encourage CMS to work with certified technology vendors to develop nimble technology platforms that facilitate real-time feedback on provider performance.

Where possible, we urge CMS to consider alignment with feedback reports provided by other payers to streamline the information provided to providers and allow for better understanding of gaps and areas for improvement.

2. **Clinical practice improvement activities should drive and support sustained, comprehensive clinical practice transformation. Transformed clinical practices view patients and families as partners in their care and incorporate patients and families into transformation efforts and governance systems. They are responsive to patient and family caregiver needs and are oriented towards achieving the goals of higher quality care, better patient and family experience of care, and reduced costs.**

The National Partnership for Women & Families strongly supports many of the clinical practice improvement activity (CPIA) subcategories outlined in statute, such as expanded practice access, care coordination, beneficiary engagement, and patient safety and practice assessment. We commend CMS for the inclusion of these subcategories as critical steps towards transformation to patient- and family- centered care. Clinical practice improvement activities should function as a vehicle for improving quality measures and supporting transition to APMs. We are concerned, however, about the subcategory of "participation in an APM" which seems to assume that, just be virtue of participating in an APM, a practice is changing and improving how they deliver care. It is extremely important that we not just assume such transformation. Practices participating in APMs must demonstrate that they are actually moving towards meaningful transformation.

For all CPIA subcategories, we recommend that clinical practice improvement activities include only those activities central to helping hospitals and provider practices authentically provide more patient- and family-centered care. Yes/no "check the box" activities that only document the occurrence of an event – such as an evaluation, assessment, or counseling – tell us little about the quality of the care provided. In fact, there is a poor relationship between such activities and improved patient outcomes.

We appreciate CMS's 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. The Comprehensive Primary Care (CPC) initiative's Milestones offer one example of such an approach. The CPC initiative requires practices to regularly track and report progress on specific Milestones that are attributed to specific activities. This approach supports measurable progress toward improvement goals and identification of participants who may not be performing adequately or who may be in need of additional support.[2]

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[2] We do note that, while CPC Milestone 4 signals strong support for patient and family engagement, it could be strengthened to better support practice's efforts to partner with patients and families to transform care. Today, many of the elements of Milestone 4 actually work against its intended aims.

Beneficiary Engagement Subcategory

Meaningfully engaging beneficiaries and families at all levels of care delivery is critical to transformation. The MACRA RFI focuses primarily on beneficiary engagement at the point of care; as we did in our comments on the proposed 2016 Physician Fee Schedule (PFS), we continue to urge CMS to go further and 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 – all of these categories will have an impact on how care is delivered and how patients experience care. (For our full vision for meaningful beneficiary engagement, please see Appendix A for our comments on the proposed 2016 PFS.)

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 functions and capabilities can help to reflect whether practices are undertaking meaningful engagement. For example:

- Practice uses electronic shared care-planning platforms that support joint development, maintenance, and updating of care plans by patients and family caregivers as well as members of the care team.
- Practice incorporates patient-generated health data into the practice's EHRs. (The information patients provide about their health, abilities, and support needs for self-management complements clinical information generated by care teams to provide a comprehensive, person-centered view of an individual's health and health care needs.)
- Practice has processes for orienting/onboarding beneficiary representatives or Patient and Family Advisors who are involved in governing boards, advisory bodies, quality improvement committees, or other entities.
- Practice has systems/processes in place to connect patients with community-based services and supports.

Additionally, we recommend that all providers pursuing improvements in the beneficiary engagement subcategory begin with a self-assessment of beneficiary engagement practices in order to identify needs and 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 and decision making processes, but also assess beneficiary engagement activities at the levels of:

- 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 and decision-making bodies?
- Community. For example, does the provider leverage partnerships and relationships with community-based and consumer organizations to facilitate transitions in care, or

better understand the needs of the population it serves? For example, the community-based Camden Coalition Accountable Care Organization partners with a resident-led Community Advisory Council in determining how shared savings are reinvested.

If beneficiaries/consumers are engaged in the above ways, it is also valuable to seek their perspectives on how well they are being engaged. This can be achieved by, for example, asking consumers 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 to patients/beneficiaries. In our experience, while practices may believe they are effectively engaging beneficiaries/patients, asking questions of patients/consumers can help to more realistically illustrate gaps and areas for improvement.

Partnering with beneficiaries and consumers through Patient and Family Advisory Councils (PFACs) or in other meaningful ways can also support 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 get an urgent appointment when needed, Patient and Family Advisors can help the practice to understand where the problem lies (for example, as we heard from one practice, is the phone system simply disconnecting people?) and offer solutions to make it better.

As CMS considers weighting categories, we urge CMS to ensure that any weighting structure reflects the significant role beneficiary engagement plays as a strategy that furthers care improvement and transformation and cuts across clinical improvement activities. Beneficiary engagement is not simply an aim in itself, but a strategy that should be integrated and employed across all CPIA categories.

As CMS considers how to assess provider performance on clinical practice improvement activities related to beneficiary engagement, we urge the agency to consider the recommendations we shared in our comments on the 2016 PFS (see Appendix A).

Use of Health Information Technology Across CPIA Subcategories

We encourage CMS to focus on clinical practice improvement activities that leverage patients' electronic access to and use of their health information. These activities are particularly relevant for the beneficiary engagement and care coordination subcategories. A 2014 National Partnership survey found that patients with online access to the health information in their providers' EHRs overwhelmingly use this capability: 86 percent log on at least once per year, and more than half (55 percent) log on three or more times per year.[3] The data clearly show that online access has a positive impact on a wide range of activities that are essential to better care and improved health outcomes, including knowledge of health and ability to communicate with providers.[4]

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[3] National Partnership for Women & Families. (2014, December). *Engaging Patients and Families: How Consumers Value and Use Health IT*, from http://www.nationalpartnership.org/research-library/health-care/HIT/engaging-patients-and-families.pdf, pg. 28.

[4] Ibid, pg. 29.

More frequent online access has an even more dramatic impact. Patients who used online access three or more times per year reported a markedly greater impact (20 percentage points higher) across these domains of care. Even more significantly, the more often individuals access their health information online, the more they report that it motivates them to do something to improve their health – 71 percent, compared with 39 percent who used online access less frequently.[5] This frequency of access clearly has profound implications for engaging patients and improving health status. Suggestions for specific clinical practice improvement activities that build upon patient online access are included below.

Information Reconciliation: Patients and their caregivers are valuable sources of information and should be included in the reconciliation process for specific information, especially information that is likely to change between encounters with the health care system. CMS should consider an information reconciliation clinical practice improvement activity that specifically includes patients and caregivers, and leverages patients' online access to their own health information. An information reconciliation activity could include discussion and electronic documentation regarding:

- Medications actually taken (including over-the-counter drugs and herbal supplements);
- Caregiver name, contact information, and role;
- Additional care team members (primary care, specialists, ER, retail clinics, etc.);
- Health problems/complaints; and
- Advance directive status and content.

As part of an information reconciliation activity, patients could be offered the ability to record an amendment to their health record online, as they are often the first to identify errors in their own records. Increased access by individuals to their own health information will conceivably increase the number of errors identified by patients, thereby underscoring the need for this capability. This activity would help to ensure the accuracy and reliability of data stored in EHRs, while simultaneously empowering patients and their caregivers to be active partners in their health and healthcare.

Shared Care Planning: Care plans are necessary to provide a roadmap for achieving the best possible outcomes, as defined by both clinical and individual patient goals. Care plans also present a valuable opportunity to collect and synthesize patient-generated data with clinical data across care settings. Shared care plans go far to helping providers improve care coordination and beneficiary engagement. Indeed, they are the foundation and context in which effective shared decision making can occur. As part of the CPIA subcategories of beneficiary engagement or care coordination, CMS should require providers to engage their patients (and family caregivers, as appropriate) in developing shared care plans, and tracking longitudinal improvement in outcomes over time.

At a minimum, CMS should specifically consider care planning criteria regarding:

- Electronic documentation of both patient and provider (clinical) goals;

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[5] Ibid, pg. 29.

- Electronic transmission of care plans to patients/family caregivers, as well as across the care team; and
- Recording family caregiver status and roles using DECAF (Direct care provision, Emotional support, Care coordination, Advocacy, and Financial) standards as appropriate.

These pieces of information engage patients and their caregivers in the planning of care, and provide the necessary foundation for a more person-focused, comprehensive, integrated plan for care. Proactively and explicitly engaging an individual's family and caregivers in the development of a care plan helps to ensure that the individual's abilities, culture, values, and faith are respected and care instructions and care recommendations are more likely to be understood and followed. In this way, shared care planning will facilitate high-quality care and improved health outcomes.

Ideally, electronic shared care plans should utilize patient access to their health information, and enable individuals to contribute and correct health information (such as family health history, goals, chosen support individuals and networks, etc.) to help manage their care and wellbeing. Inviting beneficiaries to document patient-defined goals (or other patient-generated health data) into CEHRT (for example, by way of a patient portal) could be another criterion related to shared care planning.

In 2013, the National Partnership released a report detailing consumer priorities for health and care planning.[6] Consumers envision moving beyond the concept of a care plan as a document fixed in time, to a multidimensional, person-centered health and care planning process built on a dynamic, electronic platform. This next generation of care plans in an electronic environment would connect individuals, their family and other personal caregivers, paid caregivers (such as home health aides), and health care and social service providers, as appropriate, and provide actionable information to identify and achieve the individual's health and wellness goals. We encourage CMS to draw upon these Consumer Principles as a resource (see Appendix B).

Capture Social Determinants of Health and Link to Community Resources: Medical care delivery determines only an estimated 10-15 percent of health; the remaining 85-90 percent of health is determined by social and environmental determinants of health, such as health behaviors, genetics, and the socioeconomic and physical environment.[7] Activities that integrate social determinants of individuals' health and promote social and community involvement by linking the EHR to community and social services should ultimately be a key part of clinical practice improvement efforts. Additionally, the exchange and use of information from non-MIPS eligible providers or non-clinical settings (such as home health providers, physical therapists, or other professional care team members) would inform care, result in better outcomes and decreased costs associated with unnecessary readmissions. CMS should consider clinical practice improvement activities that require MIPS providers

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

[7] Robert Wood Johnson Foundation, *Frequently asked questions about the social determinants of health* (2010), available at http://www.rwjf.org/content/dam/files/rwjfwebfiles/Research/2010/faqsocialdeterminants20101029.pdf.

to (1) collect information from patients on their social determinants of health and/or (2) exchange information with non-clinical care settings. Relevant criteria could include developing and maintaining an automated directory of community-based programs and supports from which patients may benefit.

Technical Assistance and Support for Transformation

As practices undertake clinical improvement activities, we recommend that CMS provide practices with additional technical assistance to support sustained transformation. Robust support and assistance, paired with a staged approach to support continuous progress toward quality goals, are crucial to helping practices transform care. We were glad to see the provision for technical assistance resources in the MACRA legislation; however, we believe resources for capacity building around beneficiary engagement at all levels should be available for all practices (not just those in rural areas).

Practice transformation can be a daunting process for even the most dedicated clinicians. In our experience, with regards to meaningful beneficiary engagement, clinicians often struggle with the foundational steps of partnering with patients and families, and yet we know that such partnership, through a Patient and Family Advisory Council or other mechanisms, is an effective strategy for improving quality of care, patient experience, safety, and efficiency.

For most clinicians and practices, partnering with patients and families in care redesign is uncharted territory. While some clinicians have begun to work more collaboratively with patients and family members in individual patient care, the concept of working together with patients to redesign care at the practice level and in governance is less familiar and requires significant culture change. To leverage partnerships with patients and families to achieve real transformation, providers initially need a sustained source of tailored technical assistance. In our experience, practices also need concrete and operational tools and resources to help guide them through the process. CMS can play a pivotal role in ensuring that primary care practices are connected to strong and experienced organizations that:

- Have in-depth knowledge of and expertise in delivery system models and quality improvement strategies aimed at achieving a more patient- and family-centered, high quality health care system;
- Provide tailored and granular technical assistance, guidance, and support; and
- Have experience with successfully engaging multiple stakeholders – including providers, patients, caregivers, and communities – in deliberative and collaborative processes and change efforts.

Consumer advocacy organizations are often called upon to provide technical assistance around beneficiary engagement, but are not adequately resourced to engage in that work without the compensation that other technical assistance services receive. While we are pleased to see CMS's growing interest in beneficiary and patient engagement, we urge the agency to consider how it structures requests for proposals to advance this work – for example, by encouraging technical assistance vendors to formally partner with and dedicate resources to consumer organizations to provide this assistance.

Additional Subcategories

We support the suggested additional subcategories of Promoting Health Equity and Continuity, Social and Community Involvement, Achieving Health Equity, and Integration of Primary Care and Behavioral Health. We encourage CMS to add a subcategory that supports continuous quality improvement within a practice via the use of patient-reported outcome tools and corresponding collection of patient-reported outcomes data in a systematic way. CMS should provide guidance on acceptable PROs and require data reporting back to CMS that supports measure development efforts. Such data collection could significantly improve and expand the use of PROs in clinical practice and future development of PROMs which is frequently hindered by too few providers using a given PRO tool, and by barriers to data access.

3. The Meaningful Use category should encourage and accelerate the robust use of health information technology. The foundational goals of the Merit-Based Incentive Payment System to incentivize high-quality, efficient practices would be undermined if providers were allowed to fail any Meaningful Use measure and associated threshold and still receive (even) partial credit in the Meaningful Use category.

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 providers and patients.

Meaningful Use thresholds were carefully set such that *all* eligible providers had a chance to succeed. Accordingly, experience so far shows that, on average, providers are greatly exceeding thresholds. We encourage CMS not to undermine requirements by allowing providers to meet only selected thresholds.

Additionally, we are concerned that allowing providers to be selective about the measures on which they report will delay progress on important patient and family engagement measures such as the ability for patients to view, download, and transmit to a third party or to send a secure message to their provider. These patient engagement measures often require providers to improve policies at the practice level, and also require a larger cultural shift to viewing patients as active partners in care rather than passive recipients of care. These are changes we cannot afford to delay if we want to achieve the kind of patient engagement that is essential to better outcomes.

We understand the desire to provide flexibility for providers in this new performance model. However, the reasonable thresholds, reporting flexibility, and exemptions currently included in the Meaningful Use program already provide significant flexibility. Given the fundamental role that the meaningful use of certified EHR technology plays in promoting the ability to share and use data to enhance care delivery and patient engagement, 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.

Tiered Methodology

CMS should not adopt a tiered methodology for scoring the meaningful use of CEHRT that awards partial credit for performance below established thresholds. We suggest that CMS adopt an alternate methodology that would require providers to meet or exceed the required minimum thresholds, but would also reward high performance on certain performance measures of the meaningful use of EHRs. We propose that providers would be awarded 20 percent (out of 25 percent allocated for the meaningful use category of the MIPS composite score) for attesting to all meaningful use measures. Failure to meet any of the measures and accompanying thresholds would result in a score of zero percent.

Providers would be awarded the remaining five percent for excelling in the use of health IT in measures for two objectives finalized for Stage 3 of the Meaningful Use incentive program: Objective 6—Coordination of Care through Patient Engagement, and Objective 7—Health Information Exchange. In the Meaningful Use program, providers would fulfill these objectives by meeting the required thresholds for two of the three measures. Our proposed methodology would reward providers for meeting all three measures included in these categories. Accordingly, providers would receive 2.5 percent above their 20 percent score for meeting all three measures for each objective, respectively.

We have selected Objectives 6 and 7 as indicators of high achievement because they document uses of health information technology that have great potential to facilitate patient and family engagement, promote care coordination, and ultimately improve health outcomes. In this methodology, in order to gain the additional five percent, providers would meet or exceed the thresholds for each of the following measures:

Objective 6: Coordination of Care through Patient Engagement (2.5%)—Must Meet 3/3

- 10 percent of patients or their authorized caregivers use their ability to view online, download, and transmit to a third party their health information.
- For 25 percent of patients, providers send a secure message to the patient or respond to a patient message.
- For five percent of patients, providers incorporate patient-generated health data into their EHR, that comes either from patients themselves or non-clinical settings.

Objective 7: Health Information Exchange (2.5%)—Must Meet 3/3

- For 50 percent of transitions of care or referrals, providers send Summary of Care records electronically to physicians to whom they transfer or refer patients.
- For 40 percent of transitions of care or referrals, providers incorporate electronic Summary of Care records into their EHRs from referring physicians.
- For more than 80 percent of transitions of care or referrals, providers perform a clinical information reconciliation of medications, medication allergies, and problem list.

We believe this tiered methodology is both a reasonable continuation of the Meaningful Use program and a way to encourage increasingly robust use of certified EHR technology.

B. ALTERNATIVE PAYMENT MODELS

4. Patient Centered Medical Homes. A truly patient-centered medical home is grounded in comprehensive and well-coordinated primary care. Exemplar patient-centered medical homes utilize care teams that meaningfully partner with patients and family caregivers at all levels of care, provide ready access to care, address patients' unique needs and preferences, and provide safe, timely, and effective care.

Under MACRA, APMs that are patient-centered medical homes under § 1115A(c) of the Social Security Act would be exempt from bearing financial risk. We, therefore, strongly recommend that CMS set forth 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 patient-centered medical home (or comparable specialty practices as determined by the Secretary) will receive the highest potential score for the category of clinical practice improvement activities.

For both the MIPS and APM reimbursement programs, it is critical that robust guidelines be 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. We propose that the following characteristics be considered essential elements of a patient-centered medical home.

A Patient Centered Medical Home Provides Personalized, Whole-Person Care

The patient-centered medical home "knows" its patients and provides care that is "whole person" oriented and consistent with patients' unique needs and preferences. The practice:

- Takes into consideration the patient's life situation, including family and caregiver circumstances, his or her values and preferences, age, and home environment when making recommendations about the patient's health care and treatment plan.
- Is dedicated to ensuring patients get all necessary care, proactively identifying needed tests and treatments and ensuring patients are able to access those services. At the same time, the practice emphasizes appropriate utilization, by tailoring care to align with the needs and values of its patients.
- Has ready access to the patient's complete, up-to-date medical history, including the patient's electronic health record. The care team ensures that patients and authorized family caregivers also have electronic access to the patient's electronic health record and are able to view, download, and transmit the patient's health information.
- Offers patients and family caregivers the ability to contribute information (i.e., patient generated health data) to their medical record that is relevant to their care. The information patients and their family caregivers provide about their abilities and need

for self-management support complements clinical information to provide a comprehensive, person-centered view of the patient's health and health care needs.

- Has systems in place to help patients with health insurance eligibility, coverage, and appeals and to refer patients to sources that can be of assistance.
- Assesses whether cost is a barrier to patients' getting needed care/services and helps to meet those needs and/or connect patients and family caregivers to appropriate supports.
- Communicates with patients in culturally and linguistically appropriate ways.

A Patient Centered Medical Home Provides Ready Access to Care

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

- Ensures 24/7 provider availability by phone, email, video, or in-person during evenings and weekends. In-office appointments and tele-consultations are scheduled promptly. The patient-centered medical home offers same-day appointments and accommodates walk-ins. Care team providers can rapidly access their patients' electronic medical records outside of conventional office hours.
- Accommodates the needs of patients with limited physical mobility, English proficiency, cultural differences, or other issues that could impede access to needed examination and treatment, and/or impact patients' self-management ability.
- Facilitates patients' ready and appropriate access to services and providers outside of the practice.

A Patient Centered Medical Home Effectively Coordinates Patient Care Across Settings and Providers

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

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

included in the medication reconciliation process. Inclusion of patients and caregivers in the medication reconciliation process helps ensure the accuracy and reliability of data stored in medical records, while simultaneously empowering patients and their caregivers to be active partners in their health and healthcare.

- Robustly utilizes health information technology (HIT) and electronic health information exchange. HIT is a foundational element of improving a practice's ability to share information and communicate.

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

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

In a patient-centered medical home, patients and family caregivers are supported in managing the patient's health. The practice:

- Works with the patient and/or their caregiver to set goals for the patient's health and care and helps the patient meet these goals and manage health conditions.
- Ensures that patients and authorized family caregivers have electronic access to the patient's electronic health record. Online access to patients' health information is a critical tool for improving patients' knowledge about their health, empowering their ability to communicate with providers, and increasing their desire to take proactive action to manage their health.
- Integrates into care plans culturally appropriate community-based support resources such as social services, transportation, peer support groups, and exercise programs.
- Assesses patients who are unable to effectively manage their own care because of cognitive or physical challenges and accommodates these patients by working with family caregivers, legal surrogates or other sources of support.

A Patient Centered Medical Home Treats Patients as Partners at All Levels of Care Delivery

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

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

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

- Enables two-way communication in and outside of in-person encounters, for example through secure email messaging and/or patient portals.
- Knows about and overcomes any language, cultural, literacy, or other barriers to ensure effective communication with patients, family members, and other caregivers.
- Makes electronic information accessible to patients and family caregivers. Information is available on mobile devices and is useful to patients and caregivers. All patient-facing information and communication platforms are displayed in plain language (rather than medical jargon); in patients' preferred languages, with links to explanatory, contextual information as needed; through accessible technology platforms (including mobile devices); and at no charge.

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

- Treats patients and family caregivers with dignity and respect.
- Respects patients' choice of treatment and provider.
- Works with patients and families to help them understand why and how patient health information will be stored, exchanged, used and protected; conveys the opportunity to opt-out of data-sharing; and other consumer rights and protections.

- Ensures that no treatment decisions are made without the patient's consent and understanding.
- Ensures that examinations and discussions with or about patients take place in a setting that affords appropriate privacy from other patients or staff.

A Patient Centered Medical Home Commits to Delivery of High-Quality Care and Continuous Quality Improvement

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

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

5. **<u>Alternative Payment Models</u>. If designed and implemented correctly, Alternative Payment Models (APMs) have the promise to provide comprehensive, coordinated, patient- and family-centered care and to help drive down costs. APMs' successful achievement of all three tenets of the Triple Aim – better health outcomes, better experience of care, and lower costs – rests on their ability to meet the needs of the patients they serve and to improve how care is delivered. APMs must be able to demonstrate not only cost savings and high performance on quality metrics, but also sustained implementation of transformed patient- and family-centered care.**

The National Partnership supports CMS's efforts to move health care payment away from fee-for-service and towards value-based reimbursement arrangements. As APMs take on risk and move towards capitation-like payment models, we encourage CMS to frame this transition as an opportunity to drive delivery system transformation that results in authentic patient- and family-centered care. Indeed risk-based arrangements can give providers and practices the freedom to provide care that is not limited by the constraints that accompanied fee-for-service reimbursement.

Realizing the promise of APMs to improve care delivery requires meaningful partnership and collaboration with patients and families at all levels of care – including at the point of care, in care redesign, in governance and policy, and in the community. Additionally, engaging beneficiaries in the integration and effective use of health information technology and health information exchange is critical. Only through meaningful partnership with consumers and family caregivers – the end users of care models that APMs support – will we successfully engage patients and achieve all three tenets of the Triple Aim.

Additionally, APMs should be built upon a strong foundation of robust consumer protections that ensure consumer rights and access to care are safeguarded. These new payment models must emphasize provider accountability for improved health outcomes and care experience across all patient populations, while also safeguarding patient choice and agency. This therefore requires incorporation of both *robust quality measures and meaningful consumer protections* into all APMs.

Below, we lay out key crosscutting consumer criteria that should be required of all Alternative Payment Models. We note that these criteria should be consistent across all MACRA-eligible APMs, as well APMs in which MIPS-eligible providers are participating.

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

- **APMs must be founded upon and support evidence-based care delivery models that effectively coordinate care and incorporate patients as full members of an interdisciplinary care team.** APM clinical care models should promote the use of multi-disciplinary care teams that coordinate care across providers and care settings. Patients and families should be treated as integral parts of the care team and partners in the co-creation of their health and care. Care delivery models should demonstrate effective use of electronic health information sharing, shared care planning, shared decision making, and self-management tools in order to increase patient engagement and agency.
- **APMs should ensure that beneficiaries have ready access to care.** Patients assigned to APMs should have timely access to care, including access to providers outside of regular business hours. APMs must ensure provider availability by phone, email, or in-person during evenings and weekends, and ensure that providers schedule in-office appointments promptly. APMs should facilitate patients' ready and appropriate access to services and providers across the care spectrum, including mental health and community health providers.
- **To evaluate quality performance and ensure delivery of high-quality care to patients, APMs should be required to demonstrate ongoing assessments of quality outcomes and care experience, public reporting of quality performance data, and implementation of continuous quality improvement programs.** Quality data should be measured, tracked and inclusive of patient-reported

data, including patient-report outcomes and care experience for patients and family caregivers. In particular, measurement of and reporting on patient experience of care and patient-reported outcomes should provide actionable data that helps providers improve care delivery and supports informed consumer decision-making with respect to choosing health plans, providers, and care settings. APMs should facilitate reporting quality performance data not only at the APM or delivery-system level, but also at the individual clinician/provider level.

- **To improve health outcomes meaningfully, APMs should address social determinants of health and non-clinical factors that contribute to health and wellbeing** (e.g., housing, public safety, access to education and job opportunities, language services, availability of places to exercise, healthy food choices, and other environmental factors). Ensuring 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 support the physical, behavioral, social, and economic wellbeing of patients.
- **To improve health across all populations, APMs should address disparities in access to care and in health outcomes.** The impact and appropriateness of care for different patient populations should be monitored. Data on race, ethnicity, sex, preferred language, disability, and sexual orientation/gender identity should be collected in order to address any disparities that are identified. This data should be expanded over time to include geography and disability.

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

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

- **APMs must ensure partnership with patients and families at every level of care delivery**. A better care experience and active patient engagement requires supporting patient and family participation as equal partners not only in their own health and health care decisions, but also at the care design/redesign, governance, and community levels. APMs should demonstrate strong commitment to delivering patient- and family-centered care by promoting partnership with patients at every level of care. Patient-and family-centered care criteria should be incorporated into the clinical care delivery process, as well as into APM and governance structures and public accountability.
- **APMs should partner with patients and families to make health information electronically available and useful.** Online access to patients' own health information is a critical tool for improving knowledge of health, ability to communicate with providers, and desire to actively manage one's health. APMs should ensure that

patients and designated family caregivers can access and use their complete health information, including provider notes. Comprehensive health data should be available to all patients using diverse and accessible technology platforms, including mobile technologies, in the patient's preferred language, and free of charge.

- **At point of care, APMs should demonstrate a commitment to shared care planning and shared decision making.** Proactively and explicitly engaging patient and family caregivers in the development of a care plan and treatment decisions helps to ensure that the individual's abilities, preferences and values are respected, and care instructions and recommendations are more likely to be understood and followed. APMs should also enable patients' ability to contribute and correct health information (such as family health history, goals, chosen support individuals and networks, and advance directive content) to help manage their care and wellbeing.
- **APMs should promote and support engagement of patients and families in designing care delivery that improves care coordination and patient care experience.** For example, participation in quality improvement initiatives, establishment of Patient and Family Advisory Councils (PFACs), and electronic portal implementation and education are key ways to improve patient care experience and care coordination.
- **Consumers should be part of APM governance structures.** Consumer engagement should integrate patients' values, experience, and perspective into the governance, oversight and in policy-making. Consumers and patients participate in relevant governance boards, leadership committees, and oversight committees.
    - **Consumers should have proportionate representation.** Proportionate representation requires having more than one patient, family caregiver, or consumer representative on a governance board. APMs should ensure consumer representation on the governance board reflects the diverse patient population it serves.
    - **Consumer representatives should be "true" consumers and/or consumer and patient advocates.** "True" consumers interact with but do not directly benefit financially from the health care system. A consumer advocate or patient advocate is an individual representing an organization that has a stated mission to serve as an advocate or fiduciary for a population of consumers. Consumer and patient representatives should be able to contribute both direct experiences as care recipients and the skills associated with advocating for broader groups of patients in policy and governance settings.
    - **Consumer representatives should be meaningfully involved in decision-making**. All representatives on the governance entities (including consumer/patient representatives) should have an equal seat at the table and an opportunity to share their perspectives as decisions are made.
    - **Consumer representatives should receive orientation and onboarding support to facilitate their successful participation.** Successful orientation and onboarding strategies help to ensure that consumer advocate and patient representatives are effective in their governance roles and ultimately help APMs and delivery system models meet their quality, patient experience, and affordability goals.

To achieve lower costs, APMs offer appropriate financial incentives to providers that balance cost-saving interests with quality performance and beneficiary rights and protections.

- **In an APM, gainsharing must be contingent upon performance on quality measures in addition to cost-savings.** Financial rewards based on cost-savings alone can lead to stinting on care, but robust quality measures can help ensure patients are getting appropriate, high quality, well-coordinated, patient- and family-centered care. Participating providers must meet minimum standards of care, as indicated through quality measures, to be eligible to partake in gainsharing. Requiring eligible providers to meet robust quality metrics ensures this accountability for improving and maintaining high quality care at the same time they lower the cost of care.
- **APMs' reimbursement structures should reflect the complexity of their aligned patient population.** APMs should include risk-adjusted payment mechanisms, based on patient complexity. Payment should be adequate and flexible enough to support care coordination, transition management and medication management, and to enable providers to address non-clinical determinants of health when essential to care and outcomes. There must also be adequate payment for language services for individuals with limited English proficiency.
- **APMs must also include strong consumer protections.** Strong quality measures can help to ensure that providers do not stint on care, but as financial risk increases for providers so does the incentive to stint on care. As new models of payment are developed that encourage providers to take on increased risk, reward, and responsibility, it is important to ensure that the evolution and application of consumer protections are keeping pace.
- **Consumer protections should include choice in enrollment, provider selection, transparency regarding provider incentives and a fair appeals process.** Consumers should be notified of providers' and facilities' participation in any new payment model, including disclosure of any provider or facility financial incentives or shared savings opportunities. Consumers also should be clearly informed of the opportunity to opt-out of new payment models. And, an external appeals process should be available to consumers whose providers or care facilities are participating in a new payment model that offers providers/facilities the opportunity to profit from savings generated through the program. Additional consumer protections should include complete and consumer friendly notice requirements, greater emphasis on consumer outreach and education and adequate protections concerning alignment, attribution, and data sharing.
- **Consumers should be protected against discrimination.** APMs cannot discriminate against individuals eligible to enroll, participate, or align in any alternative payment models on the basis of race, color, national origin, sex, sexual orientation, gender identity, health status, or disability and must make assurance 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.

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

APMs should excel in the use of health information technology to improve the quality and efficiency of care in the clinical setting, as well as to engage beneficiaries in their own health and care.

- **APMs should accelerate the effective use of health information technology.** Electronic Health Records (EHRs) can help providers facilitate care coordination, analyze trends in their patient populations, and offer care that is better tailored to patients' unique needs. Providers' ability to track patients' health status in real time using health information technology can improve provider-patient communication, help patients manage their care, and improve health outcomes.

  To improve both care quality and health outcomes, it is critical that health information technology facilitate the safe and secure sharing of information, not just between providers but among patients, families and other designated caregivers (including social services and supports). Giving consumers the tools to access and manage their own health information electronically is foundational to patient engagement and achieving better health outcomes.
- **APMs should partner with patients to facilitate electronic access, understanding, and use of their own health information** Patients cannot effectively manage their health and health care, or support interoperability, without accessible and convenient information about their health status, diagnoses and treatment. At the same time, providers cannot succeed under new models of care without activated and engaged patients. The National Partnership's comprehensive national survey finds that patients who have utilized online access to their health information report that it has positively impacted their knowledge of their health, ability to communicate with their doctor, and desire to do something about their health.[8] Furthermore, our recent national GetMyHealthData campaign has illuminated barriers individuals face in accessing and using their electronic health data.[9]

  Also, as patient access to data is a key element of patient activation, providers should provide patients access to or copies of their electronic health data free of charge.
- **APMs should incorporate and require meaningful use of the following specific functions:**
  - APM participants should provide patients the ability to view, download, and transmit their health data (within 24 hours, accelerating the current timeline) via a patient portal, Application Programming Interface (API), or some other

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[8] National Partnership for Women & Families, *Engaging Patients and Families*, p. 29.

[9] Since the GetMyHealthData campaign launched on July 4th, volunteers have been requesting their health data and reporting back to us on their experience. The Tracer Storyboard outlines common themes, challenges and bright spots individuals have experienced as they try to get and use their health data. View the Storyboard here: http://bit.ly/1N6csbp.

    mechanism. The data available to patients should include data currently available in View, Download, and Transmit requirements of the Meaningful Use program, as well as clinician notes.

  - ➢ Providers in APMs should be able to send summary of care records to providers to whom patients have been referred; it is equally important that providers incorporate summaries of care into their own systems and act upon this information. These summaries of care should include the documentation of patient goals, health status evaluations and concerns, and care team members (including family caregivers).
  - ➢ APMs should enable patients to send secure messages to their providers. This could be done, for example, through a patient portal or an Application Programming Interface. APM providers should actively engage and assist their patient population in making use of this feature.
  - ➢ APMs should incorporate into their EHRs personally-generated health data. These data can include data that are generated by patients themselves or data from other care team members, such as nutritionists, physical and occupational therapists, psychologists, and home health workers.

- **APMs should utilize health information technology to further connect patients, their providers, and other resources throughout the continuum of care.** In addition to performing health information technology functions envisioned for the meaningful use category of MIPS, we encourage that APMs be required to perform additional uses of CEHRT (2015 edition):
  - ➢ APM participants should capture patient health information on care preferences, which would include advance directives.
  - ➢ APM participants should provide patients electronic education materials specific to their needs, particularly in patients' preferred languages—as the technology permits. Over time, APM participants should provide patients with access to all of their health information in the top 15 languages nationally, and Spanish at the very least.[10]
  - ➢ APM participants should document relevant social, psychological and behavioral data. These data should include non-clinical fields such as financial resource strain, education, social connectedness and isolation, and physical activity.

C. CONCLUSION

Thank you for the opportunity to respond to this 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). We reiterate our appreciation for the work that CMS is

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[10] In its recent notice of proposed rulemaking regarding Section 1557 of the Affordable Care Act, the Department of Health and Human Services proposed using "the top 15 languages spoken by individuals with limited English proficiency nationally" in order to prevent discrimination based on language and national origin. Department of Health and Human Services, "Nondiscrimination in Health Programs and Activities NPRM," 80 Federal Register 54172, 54179 (Sept. 8, 2015). The NPRM raised the question, however, whether the top 15 languages should be assessed for each state or regionally rather than nationally. Id., p. 54180.

undertaking to move us toward high-quality, patient-centered care. If you have any questions about our comments and recommendations, please contact Lauren Birchfield Kennedy, Director of Health Policy at the National Partnership for Women & Families, at lkennedy@nationalpartnership.org or (202) 986-2600.

APPENDIX A

National Partnership for Women & Families Comments on Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016 (CMS-1631-P)

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

September 8, 2015

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1631-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016 (CMS-1631-P)

Dear Administrator Slavitt,

The National Partnership for Women & Families appreciates the opportunity to offer comments on the proposed rule on Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016 (CMS-1631-P). The National Partnership represents women across the country who are the health care decision-makers for themselves and their families and who want to ensure that health care services are both affordable and of the highest quality. We are deeply invested in improving the quality and value of health care and committed to ensuring that all models of care delivery and payment provide women and families access to comprehensive, high-quality, and well-coordinated patient- and family-centered care.

We commend the Centers for Medicare & Medicaid Services (CMS) for its commitment to delivery system and payment reform initiatives that improve health care outcomes and beneficiary experience while also lowering costs. The proposed Physician Fee Schedule includes many improvements for the Medicare fee-for-service program to provide better care for beneficiaries. Specifically, we support the addition of reimbursement for high-quality, effective advance care planning, the many consumer-friendly updates to the Physician Compare Website, and the potential expansion of the Comprehensive Primary Care Initiative. We also offer initial comments on the Medicare Access and CHIP Reauthorization Act and look forward to continued work with CMS to implement the new law.

If you have any questions about our comments and recommendations, please contact Lauren Birchfield Kennedy, Director of Health Policy, at lkennedy@nationalpartnership.org or (202) 986-2600.

Sincerely,

Debra L. Ness, President

Section II. Provisions of the Proposed Rule for the Physician Fee Schedule

IMPROVING PAYMENT ACCURACY FOR PRIMARY CARE AND CARE MANAGEMENT SERVICES

The National Partnership applauds CMS's recognition of care management as a critical component of primary care, and its commitment to changing payment accordingly. We appreciate the steps CMS has taken in the past few years to refine the Physician Fee Schedule (PFS) to appropriately value care management (for example, by paying separately for transitional care management and chronic care management), and the continued commitment reflected in this year's PFS. We support adjustments to codes to reflect more accurately the extensive cognitive work and increased interdisciplinary collaboration required in chronic care management.

Further, we urge CMS to continue to pursue payment changes that reflect and recognize the activities and effort physicians and other practitioners dedicate to partnering with patients and families in managing care. We underscore that the most effective care management activities are done in partnership and collaboration with patients (and as appropriate, family caregivers). We urge CMS to take this into account when revising codes. Patients (and their family caregivers) have unique insights and perspectives to offer when it comes to their own health. Unfortunately, today many chronic care management activities are not done in collaboration with patients and families. We urge CMS to consider the valuable time, effort and resources physicians and other practitioners dedicate to collaborating effectively <u>with patients and families</u> on care management activities such as:

- Discussing patient/family goals and circumstances;
- Development and continued modification of shared care plans; and
- Shared care planning.

When done well, partnering with patients and families on these activities may require additional time and resources on the part of clinicians, but yield more successful care management strategies that better meet the needs of patients and families and lead to better health outcomes.

To this end, we encourage CMS to consider codes that reflect the additional time required to collaborate with patients and families and could be paired with other codes like medication reconciliation. To ensure meaningful engagement and to avoid gaming or abuse, such codes should be accompanied by appropriate consumer protections and by robust quality metrics that emphasis patient-reported outcomes and experience.

Finally, many care coordination services occur behind the scenes, without the beneficiary's knowledge, or as a part of another visit. Thus, beneficiaries may be surprised when charged additional cost-sharing for services they do not recall receiving. Given this, we support consideration of a model to test the effectiveness of a waiver of beneficiary cost sharing for care management services. Specifically, we support testing a waiver of cost-sharing for care coordination services, such as cognitive work. Provided such a waiver was accompanied by appropriate consumer protections and quality criteria, waiving beneficiary cost-sharing for care management services could serve both to decrease administrative burden on providers and financial burden on beneficiaries.

Establishing Separate Payment for Collaborative Care

We strongly support efforts to reward physicians for interprofessional consultations and collaboration, especially between primary care and specialist providers. However, we believe that beneficiaries should be fully aware of the involvement of specialists in their care, as well as the associated benefits of the collaboration between the beneficiary's primary care provider and a specialist.

Additionally, because of the financial liability that collaborative consultations between providers could place on beneficiaries, we support CMS's proposal to consider a Center for Medicare and Medicaid Innovation (CMMI) model to test the effectiveness of a waiver of beneficiary cost-sharing for such interprofessional consultations. As CMS states in the proposed rule, without appropriate beneficiary protections and notifications concerning inter-provider collaboration, the beneficiary could end up paying for services they were not aware were being rendered.

We also support requiring integration of health information technology into collaboration efforts undertaken by primary care and specialist providers. Specifically, as part of collaborative care/care management services, we suggest that CMS implement similar requirements to those proposed for the Meaningful Use program: providers should be encouraged to electronically send "summary of care" documents and to incorporate these documents into transitions of care.

We also direct CMS's attention to the technological requirements necessary to support collaboration amongst primary care providers and specialists. The proposed rule for the 2015 edition of Certified Health Information Technology products requires health information technology products to utilize a template for Summary of Care records (C-CDA Release 2.0), and the updated C-CDA includes the structural elements for care plans, patient goals, and health outcomes that are important to collaborative care amongst providers and between providers and beneficiaries. This rule should implement similar requirements here, in order to ensure that the data fields needed to support collaborative care are present.

Furthermore, as we transition into new delivery system models that emphasize team-based care, we note that, in the future, electronic platforms will best support collaborative care by connecting all individuals involved in the care of a beneficiary – including providers, social supports, family members, and the beneficiary – in collective efforts to achieve identified goals. As the field of collaborative care evolves, we encourage CMS to look to future uses of technologies like electronic platforms and applications to support partnerships between beneficiaries, families, and their care teams.

VALUATION OF SPECIFIC CODES

Advance Care Planning

The National Partnership supports the proposal to add new codes recognizing separate payment for advance care planning. According to the National Institute of Aging, more than one in four older adults face questions about medical treatment near the end of life, but may not be able to make those decisions on their own.[1] Cognitive impairment is common among older adults; in fact, some estimates show that over 40 percent of older adults have mild dementia or cognitive impairment and over 20 percent have severe dementia—such conditions contribute to the difficulty of individuals making end-of-life decisions on their own.[2] Unfortunately, most people have no documentation of their preferences for end-of-life care, and very few have even talked with their family or provider about their wishes.[3]

Advance care planning allows patients and families to learn about the types of decisions that might need to be made near the end of life, and to consider those decisions ahead of time. Importantly, advance care planning also allows patients to alert others, including providers and family members, about their preferences and legally document those preferences, in case a patient later becomes unable to speak for herself.

Additionally, advance care planning gives patients, and their families, the opportunity to prepare mentally and emotionally for death. Older individuals who have discussions about their end-of-life planning are much more likely to have their end-of-life preferences known and followed, and their family members suffer significantly less stress, anxiety, and depression after their family members' deaths. However, many patients may be reluctant to engage in advance care planning unless it is initiated by their provider.[4]

High quality, effective advance care planning should encompass the whole process of discussion of end-of-life care, including clarification of end-of-life values and goals.[5] According to the Institute Of Medicine, advance care planning conversations should:

- Occur with a patient's designated health care provider along with appropriate members of the clinical team and with patient-identified family caregivers;
- Be recorded and updated as needed; and
- Allow for flexible decision-making in the context of the patient's current medical situation.[6]

To implement effective advance care planning, working closely with patients and their families is critical. Implementation of and reimbursement for advance care planning should be designed to give beneficiaries and their families the support they need at the appropriate time, in an appropriate setting, delivered by the appropriate team of qualified individuals. Trained providers should:

- Proactively begin conversations with patients and family about end-of-life planning.

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[1] National Institute on Aging, U.S. Department of Health and Human Services. (2014, March.) *Advance Care Planning*. Retrieved 24 August 2015, from https://www.nia.nih.gov/health/publication/advance-care-planning

[2] Nicholas, L. et al. (2014, April.) Advance Directives And Nursing Home Stays Associated With Less Aggressive End-Of-Life Care For Patients With Severe Dementia. *Health Affairs*. Retrieved 24 August 2015, from http://content.healthaffairs.org/content/33/4/667.full

[3] (IOM) Institute of Medicine. (2015.) *Dying in America: Improving quality and honoring individual preferences near the end of life*. Retrieved 24 August 2015, from http://iom.nationalacademies.org/Reports/2014/Dying-In-America-Improving-Quality-and-Honoring-Individual-Preferences-Near-the-End-of-Life.aspx

[4] Ibid.

[5] Ibid.

[6] Ibid.

- Incorporate shared care planning and decision making into the conversation, through patient education and discussion of goals, values, and clinical evidence.
- At first assessment and at frequent intervals as conditions change, document the patient's preferences for goals of care, treatment options, and setting of care. Health and care plans should be goal-oriented, dynamic tools (not static documents).
- Convert the patient treatment goals into medical orders, and ensure that the information is transferable and applicable across care settings, including long-term care, emergency medical services, and hospital care.
- Make advance directives and surrogacy designations available across care settings, while also protecting patient privacy. Health information technology should support provider, patient, and family caregiver access to the patient's advance directive (and/or other personal information documenting the patient's preferences) from multiple care settings.
- Respect and accommodate the ethical, spiritual, and cultural values of all patients.[7]

Comprehensive advance care planning should occur in the greater context of shared care planning and shared decision making, in partnership with the patient and his or her designated family caregivers. Proactively and explicitly engaging an individual's family and caregivers in the development of a care plan helps to ensure that the individual's abilities, culture, values, and faith are respected and care instructions and action steps are more likely to be understood and followed.[8]

To ensure that the above criteria are met, we encourage CMS to define a fulsome scope of services for advance care planning and to establish clear standards for practices to ensure that providers have the capability and training to furnish these services at a high level of quality. Likewise, we recommend that CMS require providers to demonstrate that they have undergone training on how to effectively provide palliative and end-of-life care in a team setting, and that CMS certify that such training has taken place. We believe that this specialized training should be integrated into the education and credentialing of a diverse array of health care professionals across fields.

Further, we encourage CMS to connect provider reimbursements to the quality outcomes of advance care planning and not to the process alone. Providers must be held accountable both for delivering high-quality advance care planning *and* for delivering health care that is in accordance with preferences documented in advance directives. Quality measures evaluating providers on advanced care planning should, for example, capture:

- Patient verification of a meaningful discussion of advance care planning;

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[7] Adapted from National Quality Forum. (2006, December.) *A National Framework and Preferred Practices for Palliative and Hospice Care Quality*. Retrieved 24 August 2015, from http://www.qualityforum.org/Publications/2006/12/A_National_Framework_and_Preferred_Practices_for_Palliative_and_Hospice_Care_Quality.aspx.

[8] For more information, please see the National Partnership's *Care Plan 2.0: Consumer Principles for Health and Care Planning in an Electronic Environment*, available at http://www.nationalpartnership.org/research-library/health-care/HIT/consumer-principles-for-1.pdf

- Patient verification of an advance care plan that is consistent with their values and preferences;
- Patient verification of updates to the advance care plan as appropriate; and
- Patient reported data on how closely care received aligns with the advance care plan.

Finally, we note that while human interaction drives the process of care planning, technology can help make necessary information more readily available and actionable, connect all people who have a role in an individual's care plan, and provide a shared platform for the ongoing maintenance and management of an individual's care and wellbeing. Electronic platforms also make it possible to scale plans according to individual needs and various stages of life. This type of electronic tool, which allows all care team members to work towards goals identified by the patient, can facilitate a dynamic process of shared decision-making and advanced care planning.

To ensure that information on patient preferences is appropriately available across care settings, we note that the Department of Health and Human Services (HHS) should finalize the standards for patient information capture released in the 2015 Certified Health IT proposed rule. CMS should then apply the standards to advance care planning in Medicare. The standards set forth in the 2015 Certified Health IT proposed rule facilitate not only the documentation of the presence of an advance directive, but also allow for the viewing of the content. Having access to the specifics of advance directives is necessary for providers to act according to their patients' choices, and patients and providers would benefit significantly from this information being available at the point of care.

Section III. Other Provisions of the Proposed Regulations

CHRONIC CARE MANAGEMENT SERVICES FOR RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS (§ 405.2462 PAYMENT FOR RHC AND FQHC SERVICES AND § 405.2464 PAYMENT RATE.)

The National Partnership supports the scope of services included in the chronic care management (CCM) services for rural health clinics and federally qualified health centers set forth in the proposed rule. We are pleased to see the inclusion of several service requirements that will lead to the delivery of the comprehensive, coordinated care that patients want and need, including a creation of a patient-centered care document, creation of an electronic care plan, management of care transitions, and coordination with home and community services.

Many of these services, such as electronic care planning and coordination with home-and community-based providers, involve providers across the continuum of care. Moreover, features like secure messaging foster bi-directional communication between patients and providers – communication that is necessary for improving the quality of care. With respect to secure messaging, a survey conducted by the National Partnership for Women & Families found that a majority (56 percent) of patients want the ability to email their providers.[9] Secure messaging can be a tool for engaging patients and their families, thus promoting more effective chronic care management. Providing patients with electronic tools, such as secure messaging, that help them track and share information with providers in real-time helps providers address their patients' symptoms and concerns in a more timely fashion, leading to improved outcomes and positive patient care experiences.

In this outline of CCM services, CMS takes an important step forward in reimbursing providers for communication – including electronic communication – with patients and other providers in their care team. Unfortunately, such reimbursement is largely absent in the current fee-for-service payment model.

PHYSICIAN COMPARE WEBSITE

The National Partnership strongly supports efforts to make the Physician Compare website as consumer-friendly and easy to navigate as possible, with a strong set of measures that accurately and equitably characterizes provider performance and enables users to distinguish between providers on multiple dimensions of quality.

We believe that CMS has made progress toward improving the content and usability of Physician Compare and we are pleased with CMS's commitment to transparency through the public reporting of more measures and performance rates. Publicly available performance information is central to value-based performance information and we applaud CMS for increasing the information available to drive quality improvement, accountability, and consumer choice. We strongly support publicly reporting all available measures, including the Consumer Assessment of Healthcare Providers and Systems (CAHPS) summary measures for group practices, as soon as possible and support including a benchmark for all measures. (We support CMS's proposal to use the ABC methodology to establish benchmarks of attainable performance, and to use these benchmarks to feed into a 5-star summary rating.)

Regarding CMS's proposal for public reporting of qualified clinical data registry (QCDR) measures, however, we are concerned that the proposal will require consumers to access data and information published on multiple individual QCDR websites. A critical feature of Physician Compare is the ability for consumers to go to one website to compare the performance of multiple providers. Requiring consumers to find performance information on multiple websites – even if the measures are identical – creates an unnecessary barrier for consumers. We encourage CMS to consider cross-posting performance information reported via QCDR on Physician Compare, even if that information is also made public on a QCDR website directly. Cross-posting this information would enable consumers to compare QCDR-reported data with other performance data in one place, on the Physician Compare website.

CMS offers various proposals for including new information on the Physician Compare website and/or through a downloadable database. We support indicating on the Physician Compare website whether a provider or group successfully participates in a number of high-

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[9] National Partnership for Women & Families. (2014, December). *Engaging Patients and Families: How Consumers Value and Use Health IT*, from http://www.nationalpartnership.org/research-library/health-care/HIT/engaging-patients-and-families.pdf , p. 34.

value programs, including the Million Hearts initiative and the Meaningful Use Electronic Health Record (EHR) Incentive Program. We note, however, that such indicators of participation in high-value programs are most useful to consumers when accompanied by additional context and information about these programs. We also support the direction of CMS's current proposal to indicate individuals and groups who received an upward payment adjustment through the value-based payment modifier program (VM) with a green check mark as well as CMS's proposal to include more robust VM cost and quality performance information in the downloadable database. However, we encourage CMS to add more VM performance information than just upward payment adjustments to the Physician Compare website.

Similarly, in addition to continuing to report on provider involvement and successful attestation in the Meaningful Use EHR program, we encourage CMS to include a measure in Physician Compare that specifically documents whether a provider offers patients online access to their health information (the View/Download/Transmit requirement of Meaningful Use). Consumers are especially interested and likely to understand what it means to have online access to their clinical information. Indeed, patients articulate a significant demand for this feature – a recent survey demonstrates that one-third of patients would consider switching to a provider who offers online access.[10] Therefore, parsing out the measure of online access from the overall measure of participation in Meaningful Use would provide consumers a particularly valuable metric to utilize when comparing providers.

We also support including individual professional and group-practice-level quality measures stratified by race, ethnicity, sex, and gender identity, and we believe doing so will report trends in health equity that aid consumers in making informed choices and aid providers in identifying and ultimately reducing health disparities.

Individual Clinician Performance

As CMS notes, the primary goal of Physician Compare is to help consumers make informed health care decisions. CMS also notes that consumers are looking for measures regarding individual doctors and other health care professionals. Despite this, reporting performance exclusively at the group level remains an option in the Physician Quality Reporting System (PQRS), and therefore in Physician Compare. Given the acknowledged value to consumers of having information to help them choose an individual physician who best meets their needs, we urge CMS to propose a specific timetable for PQRS for mandatory collection and reporting at the individual level for all providers, regardless of group size and even within an ACO. Such reporting will not only provide information that is useful for consumers but also will drive quality improvement. We would suggest that the initial focus of such reporting be on patient experience with primary care physicians and on clinical quality performance by specialists.

Reporting of data at the individual provider level is particularly pertinent for reporting of patient experience. CAHPS results largely reflect the experience of an individual patient with an individual provider, which suggests that the actual unit of measurement is that provider and not his or her group. Moreover, this kind of information is highly valuable to consumers in selecting their physicians. Yet, currently, CMS requires CAHPS reporting

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[10] Ibid, pp. 50-51.

only for groups of 25 or more and data collection and reporting is at the group level. While suggestions to require individual-level CAHPS reporting have been resisted on the grounds that it is too expensive, one vendor has conducted field tests in which the survey cost using the standard CAHPS methodology (with a reliable sample size) was determined to be less than $150 per physician. Were CMS to adopt CAHPS reporting at the individual level, it would not need to repeat the survey every year. Rather, it could give physicians the option of retaining their scores for, say, up to three years before a re-survey would be required. The physician could pay for more frequent surveying if they wanted to improve their score.

We acknowledge that today's CAHPS instruments have their shortcomings. Given the exceptionally high value of patient experience measures, we strongly urge CMS to invest resources in evolving CAHPS instruments to be more meaningful to consumers, more efficient to administer and collect, and better able to supply providers with real-time feedback for practice improvement. Enabling individual-clinician-level collection and reporting of patient experience measures in a manner that is useful to both consumers and providers should be of high priority.

Future Proposals

CMS seeks stakeholder input on the types of quality measures that will help fill measure gaps and meet the needs of consumers and other stakeholders. We recommend that CMS emphasize outcomes, including clinical outcomes and patient-reported outcomes, patient and family experience of care, patient safety, and care coordination. For example, we recommend that CMS consider adding the Minnesota Community Measurement measures of functional status and quality of life outcomes following spinal surgery to PQRS and the other physician programs.

PHYSICIAN PAYMENT, EFFICIENCY, AND QUALITY IMPROVEMENTS—PHYSICIAN QUALITY REPORTING SYSTEM (§ 414.90 PHYSICIAN QUALITY REPORTING SYSTEM (PQRS).)

Since 2007, PQRS has been a voluntary reporting program that provides a financial incentive to providers who satisfactorily report performance on quality measures to CMS. The National Partnership strongly supports the continued progress CMS has proposed for ensuring PQRS applies to a wide range of providers and garners meaningful and useful performance information.

We support the expansion and improvement of the Qualified Clinical Data Registry (QCDR) program. Registries, particularly those that capitalize on health information technology, are an important tool for care management and quality measurement. For registries to take advantage of health information exchange, however, they need to meet certain criteria. For example, registries should electronically interface with other data sources, including both EHRs and other sources of data that may be outside the EHR (e.g., imaging, product bar code, other settings). For example, a surgeon's private practice EHR may not be integrated with the EHR at the hospital where she practices, but both the surgeon's and hospital's EHRs can supply data to the registry. They should also be able to transmit data electronically to third parties including vendors, purchasers, and CMS. We encourage HHS to finalize data and interoperability standards to facilitate health information exchange so that QCDRs and other health IT vehicles can reach their full potential.

Satisfactory Reporting Requirements

In updating the requirements for satisfactory reporting in CY 2016, CMS proposes to further standardize the expectation that providers will report on at least nine measures that cover at least three National Quality Strategy (NQS) domains, and that providers who see patients in face-to-face visits will report at least one cross-cutting measure. We support the direction and intent of these proposed changes, particularly as CMS works to improve the value and utility of the measures included in PQRS.

We strongly support the requirement to report two outcome measures within the individual and group QCDR reporting options and encourage CMS to incentivize measures that use patient-generated data such as patient-reported outcome measures (PROMs).

Quality Measures

Overall, we urge CMS to use more comprehensive measures where possible, such as composite measures rather than individual component measures. This approach raises the bar for PQRS and garners more performance information that can be used to drive quality improvement, value-based purchasing, and consumer choice. Similarly, we encourage CMS to reconsider the inclusion of documentation measures in PQRS. We strongly prefer measures that report a score or an outcome over mere documentation that an outcome was obtained.

We note that we are very disappointed that PQRS #335: Maternity Care: Early Elective Delivery/Induction and #336: Maternity Care: Post-Partum Follow-Up will no longer be maintained by the measure steward. We recommend that CMS take over maintenance of the measure or provide support to another steward to develop and maintain measures that address these critical areas for women's health.

Data Stratification

We strongly support CMS's intention to stratify and report quality measures within PQRS by disparities variables, including race, ethnicity, sex, primary language and disability status. We recommend that CMS go further and stratify by gender identity and sexual orientation, as well, to ensure that beneficiaries are getting appropriate care and screenings. This type of stratification is essential to the identification, addressing and ultimate reduction of disparities in care and health outcomes. For those providers participating in both PQRS and Meaningful Use, we note that Certified Health IT products may serve as a facilitator for measure stratification, as the proposed 2015 Edition certification criteria would include the technological capacity to filter and stratify electronic clinical quality measures by multiple variables, including sex, race and ethnicity, and patient problem list.

As PQRS and other existing quality improvement programs, including Meaningful Use, are eventually incorporated into the future Merit-based Incentive Payment System (MIPS) in Medicare, we hope that this intention to stratify CQMs by disparities variables will be sustained. Implementation across programs is critical to advancing national strategies to reduce health disparities.

Request for Input on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

We appreciate the work of CMS to implement the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). With the repeal of the Sustainable Growth Rate (SGR), MACRA will move Medicare reimbursement closer to a system that rewards quality and value rather than volume – a critical step forward.

Principles for Patient-Centered Medical Homes

The National Partnership commends CMS' focus on clinical practice improvement activities as a key performance category for determining payment under the Merit-based Incentive Payment System (MIPS). MACRA establishes that any eligible professional in a practice certified as a patient-centered medical home (or comparable specialty practices as determined by the Secretary) will receive the highest potential score for this performance category. Given the financial incentive for practices to become certified by the Secretary as patient-centered medical homes (PCMHs), we strongly recommend that CMS set forth comprehensive guidelines for PCMHs and the process by which CMS will determine whether providers have met PCMH certification requirements.

Specially, <u>we recommend adopting the following principles for defining a patient-centered medical home</u>:

- In a patient-centered medical home, an interdisciplinary team guides care in a continuous, accessible, comprehensive and coordinated manner.
- The patient centered medical home takes responsibility for coordinating its patients' health care across care settings and services over time, in consultation and collaboration with the patient and designated family caregivers.
- The patient centered medical home provides patients with ready access to care by ensuring that the provider/practice is available by phone, email, or in-person during evenings and weekends and off-hours. The available provider/practice has access to the patient's medical record. Same-day scheduling is available. The patient centered medical home ensures that in-office appointments are scheduled promptly.
- The patient-centered medical home "knows" its patients and provides care that is whole-person oriented and consistent with patients' unique needs and preferences.
- Patients and providers are partners in shared care planning, including making treatment decisions.
- Open communication between patients and the care team is encouraged and supported.
- Patients and family caregivers are supported in managing the patient's health. The patient centered medical home works with the patient or their family caregiver to develop, plan, and set goals for the patient's care and works with the patient and/or family caregiver to help the patient meet these goals.
- The patient-centered medical home fosters an environment of trust and respect.
- The patient-centered medical home provides care that is safe, timely, effective, efficient, equitable, patient-centered and family-focused.

- The patient-centered medical home is committed to quality performance improvement and collaborates with patients and families in quality improvement strategies and practice redesign, including through the use of patient reported data on health outcomes and patient feedback on the experience of care.

We believe that all of these requirements must, at minimum, be met for a practice to be certified as patient-centered medical home under MACRA.

Clinical Practice Improvement Activities

MACRA also provides six categories that must be included under clinical practice improvement activities. We encourage CMS to expand on and enhance these categories in the following ways:

"**(1)** Expanded practice access, such as same day appointments for urgent needs and after-hours access to clinician advice."

In addition to same day appointments and after-hours access, expanded practice access should also include availability by phone, email, or in-person during evenings and weekends and other off-hours. The available provider/practice has access to the patient's medical record. Moreover, "access" should be defined to include beneficiaries' ability to access their clinical information online, wherever and whenever needed, and to view, download, and share this information with family caregivers and other care team members as appropriate. Expanded access must also accommodate the needs of patients with limited physical mobility, English proficiency, cultural differences or other issues that could impede access to care or act as a barrier to successful patient self-management. Finally, expanded practice access should facilitate ready and appropriate access to a full scope of services and providers, including mental health providers, social supports, and community-based resources.

"**(3)** Care coordination, such as timely communication of test results, timely exchange of clinical information to patients and other providers, and use of remote monitoring or telehealth."

Truly coordinated care has processes in place to effectively monitor and manage all tests, referrals, and procedures; shares such information with patients and family caregivers as well as with providers, and ensures that patients receive appropriate follow up care and help in understanding results and treatment recommendations. Further, care coordination ensures smooth transitions by assisting patients and families as the patient moves from one care setting to another, such as from hospital to home. Care coordination should also help patients choose specialists and obtain medical tests when necessary. Care teams should inform specialists of any necessary accommodations for the patient's needs.

Much of care coordination is accomplished through robustly utilizing health information technology and health information exchange infrastructure. For example, the Meaningful Use program's proposed requirements for Stage 3 illustrate how health information technology can and should help support these critical components of care coordination:

- Providers receiving Summaries of Care from referring providers *incorporate* the Summaries into their EHRs. This measure effectively closes the referral loop and realizes coordination of care, going beyond the routine practice activity of *sending* Summaries of Care.
- Providers give patients the ability to send secure messages and respond to these messages in a timely manner. Secure messaging allows patients and their authorized representatives to receive and send information and questions that support person-centered communications. We do not propose requiring a specific timeliness standard, only the measurement and reporting of timeliness rates, as is current practice for industry leaders such as Kaiser Permanente.
- Providers incorporate data from non-clinical settings. Collecting and utilizing data from community settings and non-clinical providers are valuable actions that contribute to person-centered care by encompassing providers across the care continuum.

"**(4)** Beneficiary engagement, such as the establishment of care plans for individuals with complex care needs, beneficiary self-management assessment and training, and using shared decision-making mechanisms."

Meaningfully engaging beneficiaries and families at all levels of care delivery is critical to transformation. Patients and families should be primary partners in clinical improvement initiatives. The proposed rule focuses on beneficiary engagement at the point of care; we urge CMS to go further and also to prioritize beneficiary engagement at all levels of care, including in care redesign, governance, and in the community.

Health information technology can contribute significantly to beneficiary engagement at point of care, facilitating not only enhanced care coordination but also sustained partnerships between providers and their patients. Examples of clinical improvement activities founded upon meaningful use of health information technology include:

- Providers incorporate patient-generated health data into their EHRs. The information patients can provide about their abilities and the support they need for self-management complements clinical information generated by care teams to provide a comprehensive, person-centered view of an individual's health. This type of clinical improvement also builds the foundation for better measurement of patient-report outcomes and patient experience. As practices incorporate patient-generated data into the EHR, practices should be rewarded for using that data to measure and improve the quality of care and patient experience.
- Shared care planning that prioritizes patients' identification of their individual health goals and the reconciliation of these goals with clinical goals.

As noted above, beneficiary engagement at the point of care is critical to practice improvement. Truly transformative beneficiary engagement, however, means supporting patient and family participation as equal partners not just at the point of care, but also at the care redesign, governance, and community levels. Examples of robust partnership with patients and families – at levels of care – in the primary care setting include:

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

Principles for Alternative Payment Models

The National Partnership supports CMS efforts to develop and test alternative payment models (APMs) as a vehicle for health system transformation. APMs must be built on the promise of the Triple Aim – better health, better care, and lower costs. As CMS considers the criteria for APMs in MACRA, we urge the Agency to ensure that all APMs are delivering high-quality, coordinated, and comprehensive care. To ensure that APMs deliver on this promise, we recommend that CMS incorporate, at minimum, the following principles into the criteria for qualifying APMs:

- APMs must focus on providing patient- and family-centered care at all levels of care delivery. Delivery of patient- and family-centered care means supporting patient and family participation as equal partners in not only their own health and health care decisions, but also at the care redesign, governance, and community levels. Patient- and family-centered care criteria must be incorporated into clinical care model design, as well as into governance structures and accountability and compensation mechanisms.

- APM clinical care models must promote the use of multi-disciplinary care teams that coordinate care across providers and care settings. Patients and families should be considered integral members of the care team. To facilitate coordination of care, care teams should utilize health information technology and health information exchange; shared care planning, inclusive of shared decision making; and patient-oriented self-management tools.

- APMs must demonstrate a commitment to shared care planning, inclusive of shared decision making. Patients and families should be treated as integral members of the care team and providers should share health information with their patients fully and without bias. Providers should respect patients' choices and actively encourage family involvement.

- APMs should provide ready access to care. Patients should have timely access to care, including access to providers outside of regular business hours. APMs ensure practice availability by phone, email, or in-person during evenings and weekends, and providers/practices always have the patient's medical record easily accessible.

In-office appointments are scheduled promptly. APMs facilitate patients' ready and appropriate access to services and other providers, such as mental health or reproductive health care providers.

- APMs must provide safe, timely, and effective care. APMs should demonstrate ongoing assessment of clinical quality, appropriate public reporting of quality performance data, and implementation of continuous quality improvement programs. Quality data needs to be measured, tracked and inclusive of the experience of patients and their caregivers and of patient reported outcomes. Measurement of and reporting on patient experience of care and patient-reported outcomes can help consumers make wise decisions when choosing their providers and care settings. Patient reported outcomes measures should robustly capture the patient's views regarding the care they received. These high impact quality measures, which are meaningful to both consumers and providers, can help Alternative Payment Models drive quality improvement and value.

- APMs should accelerate the uptake and meaningful utilization of health information technology. To improve both care quality and health outcomes, it is critical that health information technology facilitate the safe and secure sharing of information, not just between providers but among patients, families and other designated caregivers. Giving consumers the tools to access and manage their own health information electronically is foundational to patient engagement and ensuring that patients receive high quality care. All eligible professionals seeking to participate in APMs should be required at least to demonstrate how they are using (or planning to use) interoperable health information technology to advance health information exchange in care coordination (including care coordination with patients and family caregivers) and quality improvement. CMS's Meaningful Use program establishes some common minimum criteria and thresholds for meaningful use of certified health information technology. Accordingly, APMs should demonstrate that a majority of their providers are meaningful EHR users, and report their most recent attestations.

- APMs should address the non-medical factors that contribute to health and wellbeing (e.g., housing, public safety, access to education and job opportunities, language services, availability of places to exercise, healthy food choices, and other environmental factors). Ensuring information sharing and automated connections between providers and community-based resources, agencies, and organizations 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.

- To improve health across all populations, APMs should seek to eliminate disparities in access to care and health outcomes. The impact and appropriateness of care for different patient populations must be monitored and addressed. Data on race, ethnicity, language and gender should be collected 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.

> Quality measure reporting should be stratified by demographic data. Stratifying measures by demographic data is an important tool for uncovering disparities and quality gaps as well as identifying intervention points and strategies. Alternative payment models 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 provider biases, poor patient-provider communication, and poor health literacy.

While APMs work towards the Triple Aim, <u>the models must also include strong consumer protections</u>. As new models of payment are developed that push providers to take on increased risk, reward, and responsibility, it is important to ensure that the evolution and application of consumer protections are keeping pace. Consumer protections must be enhanced as the level of risk that providers may assume increases.

Consumer protections include choice in enrollment, provider selection, transparency regarding provider incentives, and a fair appeals process. Consumers should be notified of providers' and facilities' participation in any new payment model, including disclosure of any provider or facility financial incentives or shared savings opportunities. Consumers should be clearly informed of the opportunity to opt-out of new payment models. And, an external appeals process should be available to consumers whose providers or care facilities are participating in a new payment model that offers providers/facilities the opportunity to profit from savings generated through the program.

Consumers must be protected against any form of discrimination. APMs should be prohibited from discriminating against individuals eligible to enroll in, participate in, or align with any alternative payment models on the basis of race, color, national origin, sex, sexual orientation, gender identity, health status, or disability. Moreover, APMs should 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.

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

ELECTRONIC CLINICAL QUALITY MEASURE (ECQM) AND CERTIFICATION CRITERIA; AND ELECTRONIC HEALTH RECORD (EHR) INCENTIVE PROGRAM-COMPREHENSIVE PRIMARY CARE (CPC) INITIATIVE AND MEDICARE MEANINGFUL USE ALIGNED REPORTING.

The National Partnership supports efforts to align quality measurement and requirements across CMS programs, including its proposal to align Meaningful Use and CPC initiative quality reporting. Across HHS initiatives, we urge CMS to promote the consistent prioritization of high value measures, including clinical and patient-reported outcomes, to facilitate rapid improvements in care and judicious use of public funds.

Currently, most electronic quality measures are retooled clinical process measures. The kinds of measures necessary to support new payment and delivery models are possible in an electronic environment, but systems and infrastructure must be designed accordingly. Electronic quality measurement should look across longer periods of time, utilize more data sources and consider care in other settings beyond hospitals and ambulatory care such as long-term post-acute care, behavioral health and palliative care. With these electronic connections across different parts of the care continuum, we can truly begin to measure health outcomes comprehensively. As quality measures evolve, any alignment should maintain or raise the bar in quality reporting under the Meaningful Use program.

POTENTIAL EXPANSION OF THE COMPREHENSIVE PRIMARY CARE INITIATIVE

The National Partnership encourages CMS to expand the Comprehensive Primary Care Initiative and offers the following recommendations for strengthening the program and providing additional support for providers and practices. We strongly support expanding the CPC initiative approach to new geographic regions, provided adequate infrastructure and resources are in place to support practices in achieving true transformation.

Practice Readiness

We applaud CMS for defining five comprehensive primary care functions, and in particular for continuing to signal the importance of patient and family caregiver engagement. We are concerned, however, that practices continue to struggle with the Patient and Caregiver Engagement function in a very fundamental way. While we continue to strongly support the PFAC option under Milestone 4, we are concerned that many practices continue to treat PFACs as focus groups, rather than as opportunities for sustained partnership and collaboration, and thus are not realizing the full potential of this option to improve care. While many practices may express readiness to take on this type of work, they will need support and training to ensure they are meaningfully engaging with the PFAC.

More generally, many practices continue to view engagement as a strategy to “get patients to do what we want them to do” (for example, adhere to medications) rather than as a mutually beneficial partnership that can help to improve care at every level. Many well-intended practice activities clearly reflect this misunderstanding. For example, many practices conflate shared decision-making tools with patient education. A shared decision-making tool is not an educational brochure to be handed to patients. Rather, it should serve as a tool to support a dialogue between clinician and patient within which information is shared and potential treatment options are discussed (including risks, benefits, and alternatives) in the context of a patient’s individual values and preferences.

Further, many practices continue to struggle with the fundamental idea that patient and family engagement is not simply an end in itself – but also a strategy to achieve care transformation and quality improvement goals. Significant additional guidance and support is needed to help practices understand what engagement looks like, and how it connects to achievement of other goals, such as care coordination or chronic care management, and could help support achievement of the CPC initiative Milestones.

While we commend CMS’s continued support for coordinating care across the medical neighborhood, we note that it can be difficult for primary care practices to achieve this function absent real buy-in from specialists. We are familiar with one practice that has taken steps to better coordinate care with specialists in their area, yet progress has been slow because the specialists do not have similar incentives. We encourage CMS to consider what additional incentives specialists may need in order to ensure that progress made through the CPC initiative is sustained.

Finally, while we understand that practices are at different places on the continuum of "readiness," and that alignment of requirements could generally help to reduce burden, we urge CMS to continue to support strong expectations for meaningful practice transformation. Diluting expectations in order to attract more participants in expanded regions threatens the great promise of the CPC initiative.

Practice Standards and Reporting

We strongly support the Milestones approach and commend CMS for its thoughtfulness about fostering accountability in the CPC initiative particularly with respect to patient/family engagement and experience. As we've seen in other programs, where requirements exist absent strong mechanisms for oversight and accountability, it is difficult to ensure meaningful transformation. Requiring practices to regularly track and report progress on Milestones supports measurable progress toward these goals, and identification of participants who may not be performing, may need additional support, or may be taking liberties with requirements. In other programs, for example, we have seen differing interpretations of consumer representation requirements for boards and bodies – and because there was minimal oversight, some boards had staff or retired physicians serving in patient or consumers slots, undermining the intent of including real consumer voices. Oversight is particularly important for those areas that are not assessed by quality measures.

While we support CMS's intent to streamline reporting requirements for practices by acknowledging measures reported for other programs, we again express concern about the risk of lowering expectations in the name of alignment and expansion. The Milestone approach provides a comprehensive and holistic approach to assessing progress on transformation, and mechanisms for accountability. For certain Milestones in particular, allowing practices to report on other, less nuanced measures, will diminish the measurement – for example, reporting CAHPS scores would not provide the most complete account of how well a practice is performing on patient and family engagement. The Milestone approach provides a more complete and rich view of the changes and outcomes achieved.

Practice Groupings

The CPC initiative was one of the first large-scale multi-payer delivery system and payment transformation efforts, aligning public and private support and incentives. Expanding this approach to other geographic regions could further the public/private payer alignment that providers have pressed for. We strongly support expanding the CPC approach to new geographic regions, provided adequate infrastructure and resources are in place to support practices in achieving true transformation. As CMS considers expansion, however, it will be important to continue to assess and develop a better understanding of the impact of certain regional variations on health outcomes.

In general, we support encouraging multi-site group practices to involve all of their sites (depending on sites' level of autonomy) in an expansion, in order to take advantage of shared resources and provide more consistent care and experiences for their communities. In our experience, practices with multiple sites participating in the CPC initiative have benefited not only from shared resources, but also from collaboration and shared learning across sites.

Interaction with State Primary Care Transformation Initiatives

Better coordination between the CPC initiative and state primary care transformation initiatives is key to preventing duplication of efforts and using resources more effectively to advance transformation. By developing a better understanding of the efforts already taking place in state initiatives, CPC initiative could potentially help to fill in gaps, maximize its investments in these regions and speed transformation.

Better coordination could also help to maximize stakeholder engagement. For example, we have heard from some regions that it has been difficult to involve consumers and other stakeholders, such as providers, because of the sheer number of transformation efforts underway and stakeholders' limited bandwidth. We encourage CMS to consider how CPC requirements – such as requirements for regional multi-stakeholder entities – might build on or leverage existing groups or structures in ways that are mutually beneficial.

We acknowledge the challenges in creating a "national support strategy," given the significant variations among regions, but note that regional technical assistance faculty may be well-positioned to assess and advise.

Learning Activities

Delivering on the promise of advanced primary care requires partnering with patients and families at every level and throughout the practice. Accordingly, we urge partnerships with consumers/patients/families across all five CPC functions. Real transformation requires supporting patient and family participation as equal partners in not only their own health and health care decisions, but also at the care redesign, governance, and community levels.

This kind of transformation is daunting for many practices and clinicians, and requires strong leadership, culture change, and financial and technical support. The CPC initiative has made significant investments to support practice transformation, however practices need significantly more support for patient and family engagement. An expanded CPC model has the potential to provide practices with the financial support and technical assistance necessary for achieving transformation founded upon meaningful engagement of patients and families. Such support must be sustained beyond a time-limited program or pilot, however, as transformation takes time and should be an ongoing process.

We urge CMS to consider and identify necessary supports and resources – and the entities that could provide such financial and technical resources – that are required to achieve transformation in primary care delivery, particularly with regards to engaging patients and families to be partners not only in care decision-making, but in system redesign and governance, as well. Partnering with patients and families in care redesign is uncharted territory for most clinicians and practices – and yet these partnerships are key to successful transformation. While some clinicians have begun to work more collaboratively with patients and family members in individual patient care, the concept of working together with patients to redesign care at the practice level and in governance is less familiar and requires significant culture change. To leverage partnerships with patients and families to achieve real transformation, providers need ongoing, tailored technical assistance and support, including concrete and operational tools and resources to help guide them through the process.

CMS can play a pivotal role in ensuring that primary care practices are connected to strong and experienced organizations that have in-depth knowledge of and expertise in delivery system models and quality improvement strategies aimed at achieving a more patient- and family-centered, high-quality health care system. Such organizations offer provider-tailored, detailed, and intensive technical assistance, guidance, and support and have experience with successfully engaging multiple stakeholders – including providers, patients, caregivers, and communities – in deliberative processes and change efforts. Such organizations also have experience forging trusting, mutually beneficial, collaborative relationships between patients/family caregivers/advocates and providers in care process redesign initiatives. The National Partnership for Women & Families has significant expertise in these areas and is prepared to partner in any expansion effort, having supported the CPC initiative since its inception.

Such robust support and assistance – paired with strong oversight and accountability mechanisms in the Milestone reporting requirements – is crucial to helping practices make meaningful progress on CPC Milestones, in particular Milestone 4 (Patient Engagement), which reflects the important role consumers/patients/families play in care. We offer some detailed recommendations to strengthen Milestone 4 in Appendix A.

Payer and Self-Insured Employer Readiness

As CMS considers the best methods for payers to engage with one another, participating practices, and CMS under a potential expansion, we also urge careful thought and transparency regarding when to involve consumers and other stakeholders, including in multi-stakeholder processes. Integrating consumer and patient perspectives early is not only important to create a true multi-stakeholder process, but is critical to ensuring the initiative reflects of the needs of the patients and the community.

In the initial phases of CPC initiative and in the multi-stakeholder collaboratives, we observed that even payers with the best of intentions were slow to integrate consumers (and to a lesser extent, providers). While we understand that certain early discussions are best limited to payers alone, it is important for consumers and other stakeholders to be at the table as key decisions about the program are being made.

Medicaid

Generally, we are supportive of further expansion with the Medicaid population. We believe it is important to advance primary care transformation in the Medicaid program, and again note the importance of partnering with Medicaid beneficiaries at all levels of care to ensure transformation efforts meet their needs.

We urge CMS to consider whether the support and assistance designed for practices serving large Medicaid populations should be different or enhanced to meet the needs of the Medicaid population – specifically, do providers need additional support or training to meet the five primary care aims for these populations? Individuals with Medicaid often face additional challenges outside health care that impact their health and outcomes. We would support allowing practices to use the CPC PM/PM payments to connect patients with services such as safe and stable housing or nutrition and affordable food, however, enhanced training may be needed to address these issues.

Provision of Data Feedback to Practices

We strongly support provision of data feedback reports to practices to inform their quality improvement and cost reduction efforts. However, we encourage CMS to seek alignment across payers to both reduce burden for practices and provide practices with a clearer picture of their quality performance so that practices may effectively target their improvement efforts and resources.

We believe improving and aligning data feedback reports could help to increase practice use of quality performance data, but some practices may also need some additional support to effectively disseminate, interpret, and use the data given variation in report content and frequency among payers. We know that CMS is already providing significant support to practices but this support must be strengthened and continued.

MEDICARE SHARED SAVINGS PROGRAM (§ 425.20 TO § 425.504)

Quality Measures

CMS proposes to add one new quality measure and adopt a policy to address quality measures that are no longer appropriate. Regarding the quality measure set, the National Partnership continues to have concerns over the domination of process measures that represent a single factor among many others that interact to determine outcomes. Outcomes are what matter to beneficiaries and consumers, and we urge CMS to advance its efforts to replace process measures with outcome measures for the Medicare Shared Savings Program (MSSP) and other programs.

We are particularly concerned that particularly weak process measures remain in the set being used for MSSP. For example, Screening for High Blood Pressure and Follow-up Documented (Measure 21) is a "check-the-box" measure that documents steps a provider has taken, but tells us little about the quality of care provided or its outcomes. We believe the concept of this measure is already assessed through Measure 28 (Controlling High Blood Pressure) and encourage CMS to consider removing Measure 21.

We recommended that CMS consider the Care Transition Measures 3 (CTM-3) as a standalone metric within the MSSP measure set. Coordinated care is an essential element to providing better quality, more affordable care in ACOs. Good care coordination is particularly important for vulnerable older adults, who typically use the most health care services but have the poorest health outcomes. The CTM-3 measures the extent to which patients are being prepared to participate in post-hospital self-care activities; CMS has recently incorporated CTM-3 into the CAHPS survey. The CTM-3 includes the three major domains that patients have identified in qualitative studies as critically important to their experience with coordination out of the hospital; namely understanding one's self-care role in the post-hospital setting, medication management, and having one's preferences incorporated into the care plan.

We are especially pleased with the inclusion of patient-reported outcome measures (PROMs), such as Health Status/Functional Status (Measure 7) and Depression Remission at Twelve Months (Measure 40). CMS can help to move the market towards adoption of PROMs in routine care and performance reporting by including such measures in its provider incentive programs. We urge CMS to move these measures from the reporting domain into the payment domain on the same schedule as most of the other measures – with reporting in Year 1 and payment in Years 2 and 3 – and not allow them to lag behind the other measures in the set.

Regarding the proposed handling of pay-for-performance measures that are deemed no longer to be valid, we support CMS's proposal to immediately move them to pay-for-reporting status until they can be removed.

Measuring Use of Health Information Technology within MSSP

We encourage CMS to strengthen its current measure of HIT use (ACO-11), which simply requires providers to report on whether or not they have successfully attested to Meaningful Use criteria. At a very minimum, for the reasons stated above in Section I, this measure should require a majority of participants to demonstrate that they have successfully met Meaningful Use requirements, as opposed to simply reporting on their attestation.

If CMS continues to only require that ACO participants report on whether or not they have successfully attested to Meaningful Use, we encourage CMS to require specialists to report on ACO-11 in addition to primary care providers. As a report-only measure, this metric provides useful information on adoption of health information technology without placing a disproportionate burden on specialists.

Furthermore, we suggest consideration of measures that capture some core individual meaningful uses of health information technology in addition to demonstrating overall satisfaction of Meaningful Use requirements. In addition to rewarding high performers, these measures document processes that are most relevant to the goals of ACO participants, including care coordination and patient engagement. We envision that CMS would require that providers report on these measures without holding them to specific thresholds for achievement. These measures include the extent to which:

- An ACO participant electronically sends Summaries of Care to providers to whom patients have been referred;
- An ACO participant helps its patients actually view, download, or transmit their health information (for instance, through a patient portal or an Application Programming Interface);

- An ACO participant helps its patients actually electronically exchange secure messages with their provider (for instance, through a patient portal or an Application Programming Interface);
- An ACO participant incorporates into their EHR personally-generated health data from the patient.

Such measures are especially relevant because ACOs should be leaders in coordinating care and must lead the way in fostering health information exchange. Likewise, giving patients the tools to access and manage their own health information electronically is foundational to patient engagement and high quality care. Our comprehensive national survey finds that patients who have utilized online access to their health information report that it has positively impacted their knowledge of their health, ability to communicate with their doctor, and desire to do something about their health.[11] As these measures of health information technology use evolve, we encourage CMS to incorporate not only criteria that are as, if not more, robust as the Meaningful Use program, but also equivalent thresholds.

Conclusion

Thank you for this opportunity to submit comments on the proposed rule for Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016 (CMS-1631-P). If you have any questions about our comments and recommendations, please contact Lauren Birchfield Kennedy, Director of Health Policy, at lkennedy@nationalpartnership.org or (202) 986-2600.

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[11] National Partnership for Women & Families, *Engaging Patients and Families*, p. 29.

APPENDIX A

While Milestone 4 signals strong support for patient and family engagement, there are elements that actually work against its intended aims. We offer the following recommendations to strengthen Milestone 4 and better support practice's efforts to partner with patients and families to transform care.

We urge CPC initiative to consider:

- <u>Increasing PFAC meeting frequency</u>. Currently, PFACs are required to meet either twice a year or quarterly, depending on the option selected. We have seen firsthand the negative impact these infrequent meetings can have on practice's efforts to partner effectively with patients and families in care transformation. Specifically:
    - ➢ Meeting infrequently has contributed to practices treating the PFAC as a focus group, versus a more meaningful and impactful partnership;
    - ➢ It is difficult to maintain momentum and get substantive contributions to potential solutions (and some practices feel they don't have the skills to engage the group between meetings via email or other "virtual" means to keep these conversations moving)
    - ➢ Long intervals between meetings contribute to advisor attrition/loss of interest
    - ➢ Long intervals between meetings contribute to a significant amount of rework and reorientation at subsequent meetings as advisors (and staff, at times) need to be reminded of what was discussed at prior meetings, decisions made, and how members work together.
- <u>Specifying the types of initiatives that should be undertaken with the PFAC</u>. Many practices are having difficulty moving beyond the more basic, cosmetic changes (e.g., phone system updates, or better signage) with their PFACs. While we recognize that small "wins" on more basic goals contribute to a foundation for trusting relationships between the providers and PFAC (as well as confidence that the process can work), over time PFACs should grow to focus on more significant changes to care delivery. In our experience working with practices, we have seen that:
    - ➢ Exclusively focusing on the most basic, cosmetic issues can contribute to advisor attrition because they feel they are not doing meaningful work.
    - ➢ Further, exclusive focus on these "lighter" issues makes it difficult for practice leadership to understand the real value and transformative change that can come with these partnerships.
    - ➢ Better integrating the improvement work associated with the other Milestones and the PFAC will help practices see that the partnership work is not "just one more thing to do," that is separate from everything else – but instead critical to implementing changes that will better meet the needs of patients and families, as well as staff.
    - ➢ Accordingly, for Milestone 4, we suggest adjustments that track the structure of the other Milestones, specifically, providing a menu of options from which

practices and PFACs could choose (for example, related to safety, care coordination, shared decision making, etc.). In CPC reporting, practices would share ways in which collaboration with the PFAC helped to improve the practice. We would be happy to discuss guidance and potential examples as CPC initiative considers such an option.

- If still offering a combined survey/PFAC option, create more explicit connections between the two activities. (The items above should also apply to practices selecting the combined option).
    - It is implied that the patient experience survey results should be informing, in part, the PFAC's activities, however, the connections should be emphasized. At least one initiative with the PFAC should be devoted to addressing the lowest scoring survey domains.
- If still offering a survey-only option, introduce a patient partnership component. We understand that some groups may never choose to implement PFACs, however, it is important to support them in moving toward some level of partnership with patients and families. For example, practice staff could conduct follow up calls with a subset of survey respondents to take a deeper dive into the survey responses to understand what may be contributing to lower scores.

APPENDIX B

Care Plans 2.0: Consumer Principles for Health and Care Planning in an Electronic Environment

Care Plans 2.0

Consumer Principles for Health and Care Planning in an Electronic Environment

NOVEMBER 2013

Consumer
Partnership
for **eHealth**

Many organizations are working to enhance communication and care coordination across the health care system. These *Consumer Principles for Health and Care Planning* are currently endorsed by:

American Association on Health and Disability

AARP Real Possibilities

American Hospice Foundation

APIAHF
ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM

BENJAMIN ROSE INSTITUTE ON AGING
SERVICE • RESEARCH • ADVOCACY

CAREGIVER ACTION NETWORK
CAN

cdt
KEEPING THE INTERNET OPEN • INNOVATIVE • FREE
CENTER FOR DEMOCRACY & TECHNOLOGY

CENTER FOR MEDICAL CONSUMERS

CHILDBIRTH CONNECTION
since 1918

The Children's Partnership

COLORADO CONSUMER HEALTH INITIATIVE

CPEHN
California Pan-Ethnic Health Network

healthwise
for every health decision

mame
mothers against medical error

NCL
NATIONAL CONSUMERS LEAGUE

NCLR
NATIONAL COUNCIL OF LA RAZA

NHeLP
NATIONAL HEALTH LAW PROGRAM

national partnership for women & families

SEIU
Stronger Together

UHCAN Ohio

Care Plans 2.0

Consumer Principles for Health and Care Planning in an Electronic Environment

NOVEMBER 2013

The lack of coordination and communication is one of the most ubiquitous consumer complaints about the U.S. health care system, and is a key driver of poor quality and unaffordable care. A major contributor to this problem has been the failure to plan and communicate effectively across settings and clinicians, with active engagement by all members of the care team — including individuals and their family and other designated caregivers.

Care plans are gaining increasing attention among federal health policy makers as a tool to enhance care coordination and optimize health outcomes. While the concept of a care plan is not new, there is little uniformity in what these plans look like or how they are used. To achieve robust and effective planning and communication, we must move beyond our mental construct of a care plan as a document fixed in time, to a multidimensional, person-centered health and care planning process built on a dynamic, electronic platform.[1] This next generation of care plans — Care Plans 2.0 — should function as a roadmap for patients, families, and health care providers to follow toward the best possible health or functioning.

Care Plans 2.0: A multidimensional, person-centered health and care planning process facilitated by a dynamic, electronic platform that connects individuals, their family and other personal caregivers, paid caregivers (such as home health aides), and health care and social service providers, as appropriate. The care plan supports all members with actionable information to identify and achieve the individual's health and wellness goals.

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1. **Health and care plans should be goal-oriented, dynamic tools (not static documents).**
2. **Tools that facilitate health and care planning should enable all members of the care team to securely access and contribute information, according to their roles.**
3. **Health and care plans should identify and reflect the ability and readiness of an individual (and caregiver) to successfully meet the individual's goals, as well as potential barriers.**
4. **Health and care planning and tools should facilitate decision-making and specify accountability.**
5. **Every individual would benefit from health and care planning and tools.**

As the health care system moves toward a focus on wellness, these next-generation care plans offer the opportunity for patients and their loved ones to play leading roles with their care team in identifying and pursuing the health and wellness goals most meaningful to them. Of course, early efforts to develop care plans will, and should, focus first on those with the greatest need — individuals needing more complex care, such as those with chronic conditions. However, our approach to care planning should evolve from episode- or illness-based care planning to proactive, all-encompassing wellness planning, from which all individuals stand to benefit. Proactive development of a care plan for all individuals who want one will require a shift in cultural norms and expectations. To begin the transition, the process could build upon pre-established interactions with the health care system, such as childhood immunizations, annual wellness visits, or pneumonia vaccinations for seniors.

> “As the health care system moves toward a focus on wellness, these next-generation care plans offer the opportunity for patients and their loved ones to play leading roles with their care team in identifying and pursuing the health and wellness goals most meaningful to them.”

While human interaction drives the process of care planning, technology can help make necessary information more readily available and actionable, connect all people who have a role in an individual’s care plan, and provide a shared platform for the ongoing maintenance and management of an individual’s care and wellbeing. Electronic platforms also make it possible to scale plans according to individual needs and various stages of life — supporting, for example, a woman during her childbearing years, helping to manage chronic or debilitating conditions, and ultimately guiding her advance directives toward the end of life.

If the care plan depends on having a family caregiver, the caregiver’s own needs for information and training should be identified in the planning process to ensure that the caregiver has the capacity to meet the expected responsibilities in the care plan and achieve better outcomes for the individual’s goals. Proactively and explicitly engaging an individual’s family and caregivers in the development of a care plan helps to ensure that the individual’s abilities, culture, values, and faith are respected and care instructions and action steps are more likely to be understood and followed.

The Electronic Health Record “Meaningful Use” Incentive Program offers one immediate opportunity to advance the technological foundation for care plans, and the process of care (and ultimately wellness) planning. The following set of overarching principles is a consumer-directed starting place for building the functionality to support care planning into health IT.

Consumer Principles

1 Health and care plans should be goal-oriented, dynamic tools (not static documents).

- Care plans should be centered on the achievement of goals identified by the individual (or designated caregiver), supported by appropriate clinical goals.
  - Information about an individual's needs, preferences, and values should be captured as part of the care plan and updated as needed.
  - Care plans should address the unique needs of individuals and diverse populations.
- Care plans should contain specific and measurable action steps necessary for meeting agreed-upon goals.
  - Longer-term goals should be broken down into short-term, incremental steps.
- Care plans should be flexible and accommodate real-time updates based on changing circumstances and previous experience. This may include revision of the goals themselves, as well as the individual steps in the plan.
- Care plans should reflect actions for healthy living, and should not be developed exclusively from a medical perspective.

2 Tools that facilitate health and care planning should enable all members of the care team to securely access and contribute information, according to their roles.

- Relevant information from care plans should be accessible across health care settings and to non-health care supports in the community to enable refinement and updating at the point of care.
  - Care plans should allow individuals to select and share selected information with different care team members, as the individual chooses.
  - A list of care team members and contact information should be included.
- Individuals, family and other designated caregivers, and health care providers granted access by the patient should be able to initiate modifications and record progress related to care plans, including new barriers to achieving goals and changes in circumstances or lifestyle.
  - A record of when the care plan was last updated and who made modifications should be kept.
- Care plans should be organized or customizable into different views in order to enable each care team member to see clearly what his or her assigned actions are, relative to the comprehensive plan.
  - Care plans should be displayed to patients and families in plain language and leverage accessible, consumer-friendly interfaces.

3 Health and care plans should identify and reflect the ability and readiness of an individual (and caregiver) to successfully meet the individual's goals, as well as potential barriers.

- Care planning should reference and consider race, ethnicity, language, culture, faith, sexual orientation, gender identify, and disability status, which may inform an individual's perspective on health and health goals and influence the development and implementation of care plans.
- Information about an individual's knowledge, skills and confidence related to managing one's own health and care, the individual's needs for reasonable accommodation, as well as health and health IT literacy needs, should be captured as part of the care plan and updated regularly.
- Care plans should take into consideration both barriers and facilitators to achieving stated goals.
  - Social assessment information and environmental barriers relevant to an individual's ability to achieve the agreed-upon goals should be integrated into the care plan.
  - Arrangements for additional information and supports necessary to address barriers should be included in the care plan. This may require coordination with and management of non-medical community resources and supports ("enabling services"), such as transportation, interpretation, case management, child care, and health education, in concert with medical interventions.

4 Health and care planning and tools should facilitate decision-making and specify accountability.

- Care plans should include a method of monitoring both patient and care team member progress in completing action steps, as well as in meeting agreed-upon goals to improve health outcomes and maximize functionality.
- Care plans should clearly reflect what action is to be taken, by whom, and when, in order to ensure clarity of responsibility and support coordination of care.
  - An initiation or revision of a care plan should always be followed by mutual confirmation of each relevant actor's understanding of the plan and his or her role in the plan.
- Care plans should connect to clinical decision support (CDS) tools so that clinicians are able to receive automated prompts based on patient-specific goals, preferences, and clinical information.
  - Identification of high-risk behaviors or adverse health events should trigger the modification or addition of action steps in the care plan.

5 Every individual would benefit from health and care planning and tools.

- Every individual should have the ability to initiate the care planning process and care planning should be advanced as a routine activity.
  - Development of care plans should initially be prioritized for individuals with needs that would most greatly benefit from better care coordination and planning, such as individuals with disabilities or multiple chronic conditions.
- Care plans should be established prior to a crisis situation, when possible. Care plans should be scalable to support individual needs and stages of life.
  - Care planning may not be a priority for every individual at any given time. Individuals should be able to initiate (and suspend) the care planning process consistent with their needs and priorities.

The National Partnership for Women & Families is a nonprofit, nonpartisan advocacy group dedicated to promoting fairness in the workplace, access to quality health care and policies that help women and men meet the dual demands of work and family. More information is available at www.NationalPartnership.org.

The Consumer Partnership for eHealth (CPeH) is a coalition of more than 50 consumer, patient, and labor organizations working at the national, state, and local levels to advance private and secure health information technology in ways that measurably improve the lives of individuals and their families. The combined membership of CPeH represents more than 127 million Americans.

The work of the National Partnership for Women & Families is generously supported by the Markle Foundation.

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[1] For purposes of brevity, we refer in places to "patient" and "care plan," although these terms to some could imply a medical model with a focus on episodes of illness. The independent living movement uses the terminology "integrated person-centered planning" in lieu of "care planning," which we support. Choice of terminology is particularly important for purposes of care planning and care coordination, when the worlds of independent living and health care provider intersect.

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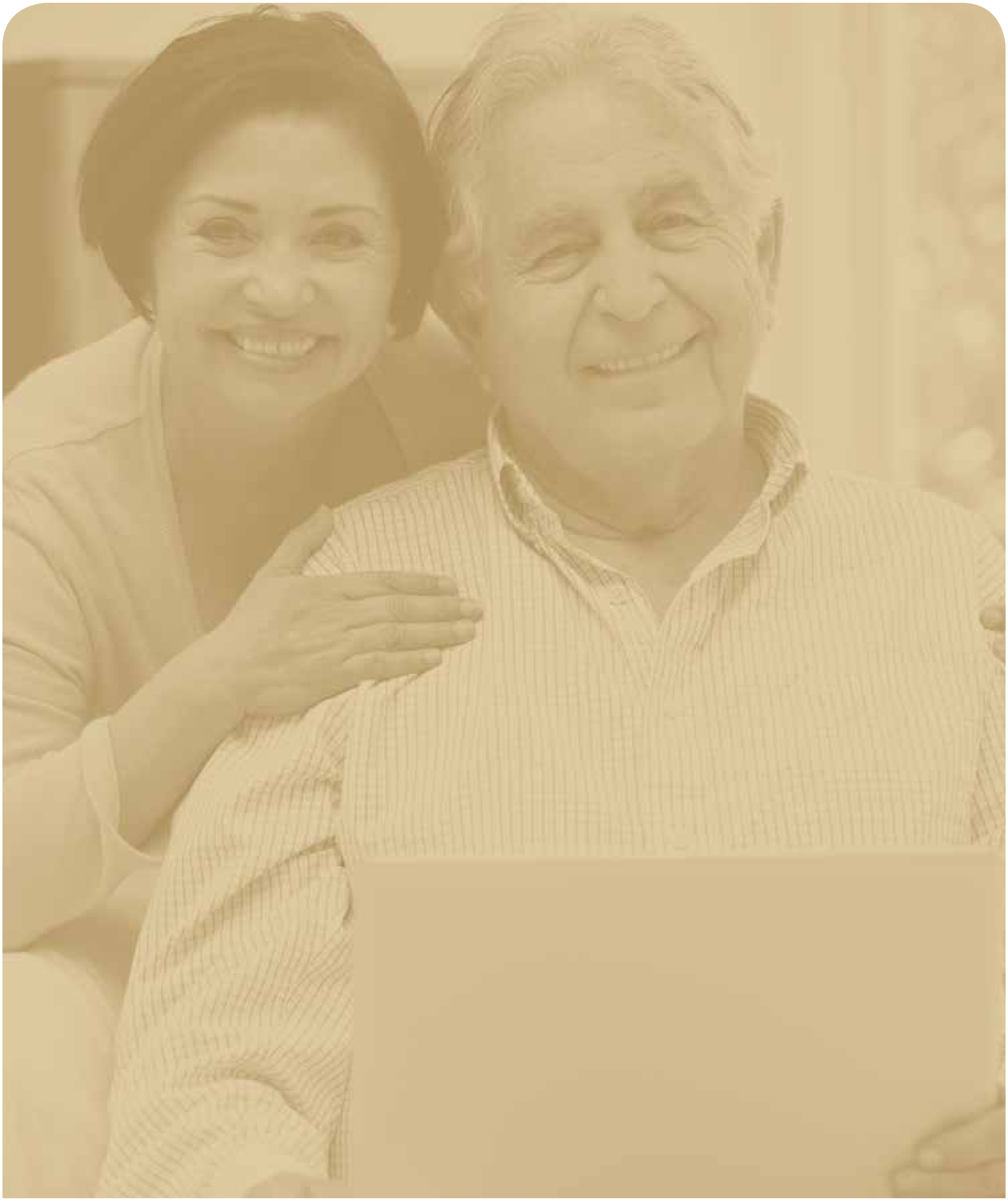

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