October 30, 2015

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services,
Department of Health & Human Services,
Baltimore, MD 21244-8016
http://www.regulations.gov

**Attention: CMS-3321-NC**

Thank you for the thoughtful and thorough questions posed in your 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. The National Committee for Quality Assurance (NCQA) strongly supports this step toward paying physicians and other clinicians in Medicare for the value, rather than volume, of care they provide.

We have separately published "A Future Vision of Medicare Value-Based Payment" white paper with five key principles for these new payment options:

***PRINCIPLE A**: Every Medicare enrollee needs a dedicated and well-organized primary care team.*

***PRINCIPLE B**: Measurement must be specified appropriately for each different unit of accountability.*

***PRINCIPLE C**: Measurement should support rapid improvement and clinical decision making.*

***PRINCIPLE D**: A core set of measures will let all stakeholders make comparisons across programs.*

***PRINCIPLE E**: Quality measure results should be easy for consumers and payers to get and use.*

The paper discusses each of these five principles in detail and invites discussion and feedback on them. We encourage you and other stakeholders to review and share your thoughts on the ideas described in these principles for a potential optimal state to support value-based clinician payment.

Below are detailed responses to specific questions in your Request for Information (RFI).

**Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) Criteria.**

You ask about the relationship between MIPS and APMs, requirements for APMs, and criteria for physician-focused payment models (PFPMs).

*MIPS & APM Relationship.* MIPS and APMs need to support comparisons within and among each Medicare payment option and the increasing levels of ability that each represents. For example, unstructured practices in fee-for-service (FFS) based MIPS have the least organization and ability to manage and improve the quality of care. Practices in organized systems like Patient-Centered Medical Homes (PCMHs) and Patient-Centered Specialty Practice (PCSPs) will have significantly greater abilities. Those in APMs will likely have more potential, as increasingly will those in Accountable Care Organizations (ACOs) and ultimately Medicare Advantage (MA) plans.

Facilitating comparison across each of these different payment and delivery system models will:

- Illustrate the degree to which increasingly organized PCMHs, PCSPs, APMs, ACOs and managed care plans support higher quality versus less organized FFS providers;
- Help beneficiaries identify the clinicians who best meet their own needs; and
- Encourage clinicians to move to more organized systems that may generate greater quality improvement and pay-for-performance potential.

Encouraging clinicians to move from traditional practice models along the continuum toward greater organization and ability to improve is a particularly important goal. The law supports movement away from MIPS with the automatic 5% APM bonus. We also support the following statutory measures and offer these suggestions on how to maximize their use:

- *Virtual Groups:* The virtual groups that clinicians may create for MIPS measurement could encourage clinicians to work together to address quality and strengthen care coordination both within and outside the group. It would be helpful to give clinicians guidance on how to form virtual groups, use them to improve integration and quality and build on them to advance farther up the continuum.
- *Meaningful PCMH & PCSP Standards:* PCMHs and PCSPs, which encourage clinicians to work cooperatively beyond their own walls, get automatic credit for MIPS Clinical Performance Improvement Activities (CPIAs). NCQA's nationally leading PCMH and PCSP programs specifically focus on coordination across settings, sharing information to close referral loops, and connecting the people they care for with community-based supports. Appendix A provides a summary of our PCMH and PCSP standards. CMS should require practices to meet NCQA PCMH and PCSP program standards or similar standards that are at least as rigorous as those developed through our multi-stakeholder, consensus-based and evidence-based process.

Additional options for creating incentives to participate in better organized systems might include:

- *Care Coordination:* MIPS could include coordination measures to assess continuity among clinicians and across settings. This should demonstrate that proactively focusing on coordination in PCMHs, PCSPs, APMs or ACOs yields better results on coordination and across the board. It also would be particularly important for specialties that treat chronic conditions for which bundled payments are more challenging and coordination and continuity is essential, like endocrinology and rheumatology.
- *Regional Aggregation for MIPS Comparison:* MIPS scores could be reported for all clinicians in specific areas, as the Medicare Payment Advisory Commission (MedPAC) suggested for comparing FFS to managed care.[1] This could help beneficiaries and clinicians see how FFS compares to APMs, ACOs and Medicare Advantage plans with better tools to improve quality. It also may resonate more effectively with beneficiaries, clinicians, and even community leaders by allowing direct comparison of locally available options.

[1] Medicare Payment Advisory Commission, *Report to Congress: Medicare and the Health Care Delivery System, Chapter 3, Measuring Quality of Care in Medicare*, June 2014.

- *Patient Panels:* CMS also could help MIPS clinicians identify their panel of patients, for example by having patients themselves identify their preferred primary care provider or via attribution as is done for ACOs. This would encourage clinicians to think in terms of their population, and provide a much clearer denominator for measurement purposes.

*APM Criteria.* For APM criteria, a first priority will be high-value performance measures to assess and improve the quality of care. High-value measures are:

1. Clinically important,
2. Evidence-based,
3. Transparent,
4. Feasible,
5. Valid and reliable,
6. Actionable, and
7. Rigorously audited to ensure accuracy.

We urge you to require APM measures to meet these criteria, as lesser measures will not provide the support clinicians need to improve.

You also should require APMs to demonstrate a proven ability to manage populations and coordinate care with other clinicians and across all settings. APMs built on the solid foundation in PCMH and PCSP standards have already documented this critical ability for success. You should further require APMs to demonstrate how they can potentially align with ACOs and MA, as well as other public and private managed care plans. NCQA's ACO Accreditation standards provide a ready-made guide for assessing these abilities.

**MIPS Identifiers**

You ask about how to accurately identify clinicians for reporting and payment purposes.

This is an important issue on which others have more expertise. However, it may be helpful to develop a crosswalk of how Tax Identification Numbers (TINs) and National Provider Identifiers (NPIs) relate to which clinician provide care under each different payment model. This will be essential for measuring quality under each payment model.

**Virtual Groups**

You ask how to assess eligibility, participation and performance in virtual groups.

We suggest that you be guided by the potential for virtual groups to be a first step toward more organized and able APMs. For example, the degree to which a proposed virtual group meets PCMH or PCSP standards would indicate its ability to coordinate and improve quality.

You should require all members of a TIN, which by definition is already a specific legal entity, to be in a virtual group. Approving virtual groups with only some TIN participants would undermine potential for even these rudimentary entities to help clinicians move towards PCMHs, PCSPs, APMs and other, more organized and able systems. You also should require virtual groups to serve similar populations in a specific geographic area, like hospital referral regions.

**Performance Measures & Reporting**

You ask whether to maintain all seven current performance reporting options, how many and what types of measures to include and whether to stratify results by beneficiary demographic characteristics.

On reporting options, we urge you to phase out claims reporting, as well as potentially the Group Practice Reporting Option (GPRO), as both require manual input that creates potential for errors, selection bias and even outright gaming. As these phase out, you should move to reporting of data drawn directly from and validated through electronic health record (EHR) entries that occur in the natural workflow of providing care. This will minimize potential for errors, bias and gaming as well as the administrative effort to report.

*Number & Types of Measures.* Rather than the total number overall, it is much more important to assess each measure's value in helping clinicians improve and helping beneficiaries and other stakeholders make meaningful comparisons. Measures meeting the seven criteria described above likely will have such value and not place undue burden on practices. Measures not meeting those seven criteria likely will have little impact and create undue burden on practices. The desire to reduce burden should focus on selecting high-value, high-impact measures and efficient data collection, not arbitrarily limiting the number of measures.

You should include measures covering all the important domains identified in the National Quality Strategy, which were developed through a consensus-based, multi-stakeholder process. This is critical for promoting harmonization in performance-based payment and other quality improvement efforts among all public and private payers who look to the National Quality Strategy for guidance. We note, however, that the efficiency domain may be challenging in MIPS because of small numbers and large variations. This again underscores the need for regional aggregation for MIPS comparisons.

For types of measures, we appreciate the great interest in moving toward more outcomes measures. However, the existing pool of outcomes measures is limited and likely to grow significantly only after more widespread use of EHRs and re-specification of existing measures for electronic reporting. Even with more outcome measures that meet high-value criteria, application of them by individual clinicians under MIPS is problematic, given the likelihood of numbers too small for statistical significance. This is exacerbated by the inability to risk adjust sufficiently. This introduces the very real possibility of holding clinicians accountable for outcomes over which they have only limited influence.

Instead, you should include only outcome measures for which individual clinicians have statistically sufficient numbers and meaningful ability to affect results. You will need structure and process measures that meet our seven criteria and are directly linked with outcomes, such as on high-value preventive care services, which point clinician to needed improvements. You also should encourage collection of data on patient-reported outcomes and accountability at a larger, regional level.

*Demographic Characteristics.* We strongly believe you should stratify results by beneficiary demographic characteristics whenever there are sufficient numbers to do so in a meaningful way. This will help clinicians and all other stakeholders identify, target and track improvement over time in reducing and ultimately eliminating disparities in care.

It is equally important that you do not risk adjust measure results themselves for beneficiary demographic characteristics. Doing so would mask rather than highlight disparities, and unfairly lock in lower expectations for the very populations that most need better quality.

Instead, we urge you to explore payment strategies that adjust for the greater effort that high quality for more vulnerable populations may require. This is a better way to avoid the unintended consequence of doctors dropping or avoiding "difficult" patients and therefore leading to deepening disparities.

**Consumer Assessment of Healthcare Providers and Systems (CAHPS)**

You ask whether to use the CAHPS survey in assessing performance or CPIAs.

It will be essential to include patient experience-of-care measurement in both MIPS and APM, as this is one leg of the "triple aim."

We believe, based on our experience encouraging PCMHs to use the Clinician-Group CAHPS, that the effort to gain patient feedback needs substantial improvement. The CAHPS tools have sound psychometrics and address important topics, but the current methods of administration are costly and the survey tools are lengthy and generates low response rates. The current approach also includes questions that consistently predict answers to other questions, and thus could be reduced in size by up to one third and still yield the same results. We urge you to explore more efficient ways to generate patient experience feedback that give clinicians this invaluable data as close to real time as possible, such as a mobile app.

**Specialty Measures**

You ask how to apply MIPS to specialties without sufficient numbers of high-value measures, and whether to maintain the Measure Applicability Verification Process.

We appreciate that several specialties currently have few, if any, measures that meet our criteria for high-value. It is critically important to *prohibit* such specialties from reporting on measures not meeting these criteria, as doing so would increase administrative burden with very little impact on quality. Instead, the measurement development plan that CMS is required to finalize by May of 2016 should focus heavily on how to develop high-value measures to fill these important gaps.

While work to fill those gaps is underway, you could look to the structural measures in our PCSP program as an interim alternative. These measures focus on referral agreements for two-way communication with primary care providers, enhanced access – including same-day appointment availability, medication management and other quality priorities that apply across specialties.

We also urge you to maintain the Measure Applicability Verification Process. This process assesses whether clinicians submit on the measures appropriate to their practice and/or could have submitted additional measures. This is particularly important for specialties that lack sufficient numbers of high-value measures.

**Barriers to MIPS Reporting**

You ask what barriers clinicians might encounter when working to report in MIPS.

The FFS system upon which MIPS is based is itself a barrier because it does not tell clinicians in advance which patients they are accountable for, known as such prospective attribution. FFS also supports small practices with too few patients for statistically valid measurement, and does not encourage movement toward more organized systems better able to measure and improve quality. FFS-based MIPS further has potential for some patients to fall through the cracks because they lack enough experience with any one clinician to be assigned to any one clinician. This could make MIPS look better than APMs or Medicare Advantage because it may not include the full population.

These serious limitations are why value-based payment enjoys broad support, and why Medicare needs to make the most of virtual groups, regional MIPS assessments and substantial APM financial incentives offer to accelerate movement toward more value-based pay.

**Data Integrity**

You ask several questions on protecting accuracy of data reported for value-based payment.

Above all, it is critical to require rigorous auditing, oversight, or retrospective accuracy checks for all reported data to ensure reliable, valid results. A concurrent audit is the best process. We saw several questionable practices with potential to weaken HEDIS®[2] data integrity when results were first used to adjust Medicare Advantage plan payments. Rigorous auditing helped us to promptly identify and address these poor data practices, and will be similarly essential for protecting the integrity of MIPS and APM data now that significant dollars are attached.

For EHR and registry testing, system checks are needed, including code certification, code review and data collection review of how you get files from clinicians and then calculate results. You should have standards for registries like certified EHR Quality Reporting Document Architecture. Ideally, all reporting options should have the same data formatting and submission method. You should require registry and EHR review to ensure that the form and manner are met. Feedback during testing should include all information with the system or clinician, with full disclosure of processes and findings. And it is not sufficient to just test the reporting format of the data (e.g. PQRS submission process); it is also essential that the logic within the system(s) that aggregate the data for reporting purposes have also been tested to result in a nationally comparative result.

The threshold for data integrity should be as high as possible, given the impact on beneficiary health, taxpayer dollars and fairness among clinicians. We therefore support strong action, up to and including disqualification for participation in Medicare and other federal programs, for both clinicians and vendors who fail to meet integrity standards. Intermediate actions could, when appropriate, include conversations, learning opportunities and corrective action opportunities. Strong data integrity provisions are necessary to protect beneficiaries, taxpayers and clinicians, since MIPS is budget neutral and errors, inadvertent or not, will take dollars from both Medicare and other clinicians.

[2] HEDIS, the Healthcare Effectiveness Data & Information Set, is a registered trademark of the National Committee for Quality Assurance.

**Certified EHRs**

You ask what should constitute use of Certified EHR Technology (CEHRT) for MIPS, and whether EHRs should capture, calculate and/or transmit measurement data.

We urge you to apply final Stage 3 Meaningful Use (MU) rule, on which we commented previously. On capture, calculate and/or transmit, it is essential for EHRs to capture and transmit, but not necessarily to calculate, as there are vendors and other options for that function.

We would also draw your attention again to the need for data integrity. The current MU certification program for quality measure reporting does not rigorously test the thousands of potential data parameters that each measure represents and is therefore inadequate to expect to receive nationally comparative results from those certified systems. NCQA has established an eMeasure certification program to address this and encourages CMS to investigate how we could be useful in this effort.

**Resource Use Measures for MIPS**

You ask what resource use measures to use, how to align with other Medicare resource measures, whether to include Part D, benchmarks to use and how to align resource and quality measures.

We urge you to use HEDIS Relative Resource Use (RRU) and Choosing Wisely measures, in addition to Total Per Capita Costs for All Attributed Beneficiaries and Medicare Spending per Beneficiary measures.

*Relative Resource Use Measures:* RRUs track all resource use for people with five common chronic conditions that account for over 50% of health spending – asthma, cardiac disease, chronic obstructive pulmonary disease (COPD), diabetes and hypertension. RRUs are broader than the Total Per Capita Costs for Beneficiaries with Specific Conditions (diabetes, coronary artery disease, COPD and heart failure) measure. They are thus better suited for harmonization with other programs – a key goal for MIPS and measurement overall. Results are derived from claims and based on Medicare prices and risk adjustment. We report each condition in five categories: evaluation and management; inpatient hospital care; surgery and procedures; outpatient prescription drugs; and laboratory and imaging.

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

Use of prescription drugs is an important exception to the weak correlation between resource use and quality. Appropriate drug use can reduce higher-cost services like hospitalization and chronic disease complications. It therefore will be critical to include Part D prescription drug utilization in MIPS resource use measurement.

To further align resource and quality measures, it will be important to distinguish good resource use, such as high-value preventive services and prescription drugs, from overuse and inappropriate use, such as imaging for uncomplicated low back pain. HEDIS includes some overuse measures, for example on imaging for low back pain, but more are needed.

*Choosing Wisely* measures would track additional services that physicians themselves agree are wasteful. Despite this broad consensus, there has been little progress on reducing their use.[3] Adding Choosing Wisely measures into MIPS would provide much-needed financial incentives to reduce the waste and harm to patients from these dubious services. However, these measures would need to be developed for MIPS and would require clinical data that largely resides in EHRs rather than claims.

You could use all of these recommended measures to align MIPS with other Medicare resource use measures. Total cost and RRU measures, for example, can apply to all types of clinicians when they are truly part of comprehensive care teams. Applying these measures to all clinicians would encourage specialists, such as radiologists and pathologists, to be full team members and not merely process orders without sharing their expertise on tests' value.

For benchmarking, clinicians and other stakeholders should be able to compare results to rates for other clinicians to local, state, national rates for other clinicians overall and by specialty. It also will be important to be able to compare MIPS to clinicians in APMs, ACOs and MA plans.

Finally, we urge caution on measuring individual clinicians' resource use, which could be statistically challenging given potential small numbers. This again reinforces the importance of virtual groups and encouraging movement to APMs and other more organized systems.

**Clinical Practice Improvement Activities (CPIAs)**

You ask what criteria to apply to CPIAs, whether it should include additional activities to those described in statute and how to validate and evaluate CPIAs effectiveness in addressing key priorities.

CPIA criteria should be the same as standards for PCMHs and PCSPs, which already closely parallel much of what is in the statute. NCQA's PCMH and PCSP program standards are the most widely used, and are either the same or closely parallel standards in other programs. Appendix B summarizes PCMH standards used in state-based programs, with substantial similarities across states and NCQA's nationally leading program.

To evaluate CPIAs, you could collect beneficiaries' perspective on priorities like access, literacy, engagement and community resource links. For the key issue of equity and reducing disparities in care, you could look for alignment with the Office of Minority Health's standards for Culturally and Linguistically Appropriate Services. These address the need to understand and meet the cultural and linguistic needs of clinicians' patients/families by:

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

[3] Rosenberg et al, *Early Trends among Seven Recommendations from the Choosing Wisely Campaign*, JAMA Internal Medicine, October 12, 2015.

NCQA PCMH and PCSP standards specifically address cultural and linguistic needs, collection of data on race/ethnicity, and attention to evaluating and improving performance for vulnerable populations and reducing disparities.

**Meaningful Use (MU)**

You ask whether scores for the MU portion of MIPS should be based on full or partial MU achievement, or tiered to determine achievement levels above and below thresholds.

We suggest the tiered approach, which would help clinicians compare themselves to local, state, national and/or specialty benchmarks and identify priorities for improvement.

**Other Measures for MIPS**

You ask what types of measures used in other payment systems to include, what to use for specialties lacking high-value measures, and how to link clinicians to facilities and data sources.

MIPS measures need to align with APMs, ACOs and MA plan measures so clinicians, beneficiaries and other stakeholders can make meaningful comparisons within and across each of these different payment options. However, measures must be specified for each option to account for the amount of information and influence clinicians have in differently organized settings.

For individual MIPS clinicians, which will include the least organized practices, you should use measures for processes strongly linked to outcomes, like high-value preventive care screenings and good chronic care management. These are well within individual clinicians' control.

Population-based measures, like preventable hospital admissions and readmissions, are critical for apples-to-apples comparison of MIPS clinicians in aggregate at regional or national levels to APMs, ACOs and MA plans. MedPAC, again, has suggested aggregating clinicians in a community or geographic region for measures with limited meaning for individual clinicians. While individual clinicians might wonder about their contribution to a geographic region's performance, stakeholders need to understand the performance among the large number of clinicians outside coherent accountable entities. Local aggregation would allow comparisons of population-based measures among clinicians in a region under MIPS versus those in APMs, ACOs and MA plans.

Outcome measures are generally not appropriate for individual clinicians who have little ability to influence the outcomes. Holding individual clinicians responsible for outcomes when they lack shared accountability frameworks may create adverse incentives to avoid vulnerable and complex patients.

*Measures for Specialists:* For specialties lacking sufficient high-value measures, broad population-based outcome measures such as readmissions can again apply in aggregate, but not for individual clinicians. It is critical to develop sufficient high-value measures for each specialty. Applying measures that do not fit a specialty's practice will be meaningless, skew overall MIPS scoring and undermine the intent of value-based payment. The measure development plan required by May of 2016 should focus heavily on how to fill such measurement gaps.

Some gaps, such as for hospital-based specialists, may be easy to fill by re-specifying existing hospital measures. Others require more work, including development of evidence on treatments that now are not evidence-based, which needs to begin as soon as possible.

*Data for Measurement:* To obtain data for measurement, the ideal source is EHRs and registries that capture needed information as part of routine clinical care workflows. This provides the most accurate data, minimizes both potential for errors and administrative efforts to report and creates a basis for much more rapid feedback to clinicians for quality improvement purposes. All measurement data, from electronic or other sources, must be audited for accuracy. Measurement data also needs to include PROMs and other patient-generated data. Existing patient experience surveys and measures must be improved to increase response rates and utility to clinicians.

**Performance Standard Development**

You ask what historical standards and benchmarks to use, and how to define, measure and incorporate improvement opportunities - and improvement itself - into MIPS.

We suggest that you use prior year results as benchmarks, and do so independently of group size. Results should be stratified by socioeconomic status for analysis to identify and track progress on reducing disparities. However, results should be not risk adjusted for socioeconomic status, which would mask rather than highlight disparities.

To define and measure improvement, we suggest weighting methods like those used by California's Integrated Healthcare Association and Florida's Medical Quality Assurance program. You should take improvement potential into account. For example, clinicians with a score of 60 on a given measure have 40 potential points of improvement, while clinicians scoring 90 have only 10 potential points for improvement. You need to periodically update improvement definitions and baselines to promote continual improvement. You also need to consider improvement at composite measure levels, where there will likely be more statistical significance than at individual measure levels.

**Weighting Flexibility**

You ask how to weight results when providers cannot be assessed in some categories, and how to determine when that is the case.

To weight results for providers who cannot be assessed in some categories, we suggest increasing weights for other measures. This is NCQA's practice for scoring in our clinical programs. It is critical to not assess performance on categories that are not applicable.

To ensure statistical significance in results, we suggest using standards developed for our Physician Hospital Quality (PHQ) certification program. PHQ provides impartial third-party certification that clinicians and hospital ratings programs use statistically valid, transparent methodologies that assess quality as well as cost.

**Composite Scores and Public Reporting**

You ask how to assess each performance category and combine results into composites, and how to publicly report results.

We suggest using an approach similar to the Medicare Advantage Star Ratings methodology. It combines individual measure scores into user-friendly composite scores for topics that resonate with beneficiaries, such as Staying Healthy and Managing Chronic Conditions.

This methodology will best facilitate comparison of quality between MIPS clinicians and Medicare Advantage plans and other payment options. Weighting of quality and resource use measures across National Quality Strategy domains should consider which results promote the best value.
For public reporting, NCQA's PHQ standards described above provide a solid foundation for both validity and transparency. Results, but not measures themselves, should be stratified by patient demographics to support efforts to identify and reduce disparities.

**Feedback Reports to Clinicians**

You ask how and what information would be most helpful to clinicians, whether and what feedback to share on CPIAs, how to incorporate data from other providers and payers and who should have access to feedback reports.

Feedback should include quality and resource use results with patient Hierarchical Condition Category (HCC) information, compared to local, state, national and specialty benchmarks. To incorporate data on other payers, you need to have clinicians report data on all their patients, as Medicare requires now for hospitals. Information on care from other clinicians and suppliers should include who they are, what they provided and a breakdown of their MIPS scores. CPIA feedback should include how much clinicians achieve of the potential 15% of MIPS score across the same benchmarks.

To further enhance feedback, we encourage you to explore development of an interactive tool that helps clinicians to delve deeper into their scores, comparisons to others and best practices for improvement.

Access to reports should generally be left up to clinician discretion. A critical exception will be for virtual groups, where all members of a group need full access to reports on all other members.

**Alternative Payment Models (APMs)**

You ask how to determine which state PCMH initiatives are comparable to Center for Medicare & Medicaid Innovation initiatives. You also ask how to determine whether APMs have measures comparable to MIPS and non-Medicare payers, and what meaningful use criteria to require.

For assessing state PCMH initiatives, we again refer you to Appendix B, which summarizes PCMH standards in state-based program, and shows substantial similarities across states and with NCQA's nationally leading program.

To further assess state-based initiatives, we suggest requiring independent validation of any data on quality or resource use impact. You should apply the same criteria to any multi-payer PCMH initiatives.

To determine whether APM, MIPS and non-Medicare measures are comparable, we suggest using a core measure set that applies across populations and specialties. Such a core set allows comparison across MIPS, APMs, ACOs MA plans and other payers, with appropriate specifications for each unit of accountability.

Core set measures will address a common set of domains, identified with multi-stakeholder input, such as those identified by the National Quality Strategy.[4] Many existing measures address possible core domains, such as preventive and evidence based care, and could facilitate cross-program comparison. The core set can then support nesting of measures needed for other purposes. For example, groups of measures can be used as building blocks that are aggregated for each core quality domain. Domain scores meet the needs of consumers who prefer higher-level quality data, and other stakeholders seeking to focus on a reduced measure set.

You will also need measures outside the core set for certain sub-sets of populations and clinician types. These include measures that specifically address the unique needs of vulnerable populations, including patients with functional and cognitive limitations and serious mental illness. They also include measures for specific medical specialties providing unique services not addressed in the core set.

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

**Physician-Focused Payment Model (PFPM) Technical Advisory Committee**

You ask what to require in proposals, criteria to use in assessing proposals. You also ask how to promote specialist models and whether you should apply different criteria to them.

You should first require that APMs use only measures meeting for high-value measurement criteria:
1. Clinically important,
2. Evidence-based,
3. Transparent,
4. Feasible,
5. Valid and reliable,
6. Actionable, and
7. Rigorously audited to ensure accuracy.

You also should require any proposal to demonstrate an ability to coordinate with other clinicians and across settings, as well as to align with ACOs, MA plans and other payer initiatives. NCQA's ACO Accreditation standards, designed to help ACOs meet the highest standards for all payers, provide a clear checklist for assessing these abilities.

[4] http://www.ahrq.gov/workingforquality/

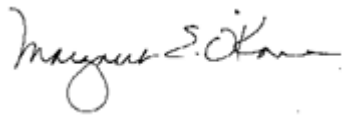
Proposals for any new models should state why they are a priority and how they differ from current approaches. You also should not reject proposals using or extending existing models that, if successful, should be allowed to flourish.

However, proposals that include previously tested models should be required to include background and independent assessment of their results. Finally, we agree that you should consider proposals incomplete if they lack the list suggested in the RFI, including:

- Definitions of target population, how they differ from other patients and the number of beneficiaries affected,
- How the model impacts quality and efficiency,
- Whether the model pays based on quality measures and if so whether the measures compare to MIPS,
- Specific quality measures, their prior validation and how they further goals including experience, quality of life and functional status,
- Impact on access to care,
- Impact on disparities,
- Geographic location,
- Scope (specialties) of participants,
- Number of expected participants and whether they have expressed support,
- Requirements for participant EHR use,
- Assessment of participant financial opportunities/business case,
- How the model fits/replaces/interacts with existing Medicare payment systems,
- The incentive/performance-based payments,
- Amount/type of participants financial risk,
- Participant patient attribution method,
- Estimated spending impact and expected new Medicare/Medicaid payment to participants,
- Estimated Medicare/Medicaid savings,
- Information on similar private payer models and whether the model could include them,
- Whether the model engages other payers, if not why not, and percentage of patients covered by Medicare vs. others,
- Potential CMS evaluation approaches (design, comparison groups, key outcomes), and
- Opportunities for expansion if successful.

Thank you for the opportunity to comment. Please contact Paul Cotton, Director of Federal Affairs, at 202 955 5162 or cotton@ncqa.org if you have any questions.

Sincerely,



Margaret O'Kane,
President

## Appendix A: Summaries of NCQA Patient-Centered Medical Home (PCMH) & Patient-Centered Specialty Practice (PCSP) Standards

| NCQA PCMH Standards (2014) | Summary of Requirements |
|---|---|
| **PCMH 1: Patient-Centered Access** | • The practice provides 24/7 access to team-based care for both routine & urgent needs of patients/families/caregivers<br>• The practice has a written process & defined standards for providing access to clinical advice & continuity of medical record information at all times<br>• The practice provides information & services through a secure electronic system |
| **PCMH 2: Team-based Care** | • The practice provides continuity of care using culturally & linguistically appropriate, team-based approaches<br>• The practice has a process for informing patients/families about the medical home role |
| **PCMH 3: Population Health Management** | • The practice provides evidence-based decision support & proactive care reminders based on complete patient information, health assessment & clinical data<br>• The practice uses an electronic system to record patient information as structured (searchable) data<br>• The practice collects & regularly updates a comprehensive health assessment<br>• The practice proactively identifies populations of patients & reminds them, or their families/caregivers, of needed care<br>• The practice implements clinical decision support+ (e.g., point-of-care reminders) following evidence-based guidelines |
| **PCMH 4: Care Management & Support** | • The practice systematically identifies individual patients & plans, manages & coordinates care, based on need.<br>• The practice establishes a systematic process & criteria for identifying patients who may benefit from care management.<br>• The care team and patient/family/caregiver collaborate to develop & update an individual care plan<br>• The practice systematically implements a process for managing medications and uses electronic prescribing<br>• The practice demonstrates use of shared decision making |
| **PCMH 5: Coordination & Transitions** | • The practice systematically tracks and follows up on tests and coordinates care across specialty care, facility-based care & community organizations. |
| **PCMH 6: Performance Measurement & Quality Improvement** | • The practice uses performance data to identify opportunities for improvement & acts to improve clinical quality, efficiency & patient experience, including care coordination and resource use<br>• The practice obtains feedback from patients/families on their experiences with the practice and their care<br>• The practice uses on ongoing quality improvement process, demonstrates continuous quality improvement and produces performance reports |

| NCQA PCSP Standards | Summary of Requirements |
|---|---|
| **PCSP 1: Track & Coordinate Referrals** | • The practice has formal & informal agreements & specified methods of communication with PCPs & other referring clinicians<br>• The practice has a monitored process to track referrals that includes consideration of the urgency & type of referral.<br>• The practice has a monitored process to ensure a timely response to PCPs, referring clinicians & patients. |
| **PCSP 2: Provide Access & Communication** | • To provide access, the practice has a written process, defined standards & demonstrates that it monitors against those standards.<br>• Patients have access to culturally and linguistically appropriate services & clinical advice.<br>• The focus is on team-based care with trained staff. |
| **PCSP 3: Identify & Coordinate Patient Populations** | • The practice collects demographic & clinical data for population management.<br>• The practice assesses & documents patient risk factors.<br>• The practice identifies patients for proactive reminders. |
| **PCSP 4: Plan & Manage Care** | • The practice assesses patient/family self-management abilities.<br>• The practice works with patient/family to develop a self-care plan & provide tools & resources, including community resources.<br>• The practice reconciles patient medications at visits & post-hospitalization.<br>• The practice uses e-prescribing. |
| **PCSP 5: Track & Coordinate Care** | • The practice tracks, follows-up on & coordinates tests, referrals to secondary specialists & care at other facilities (e.g., hospitals)<br>• The practice manages care transitions |
| **PCSP 6: Measure & Improve Performance** | • The practice uses performance & patient experience data to continuously improve<br>• The practice tracks utilization measures such as rates of hospitalizations & ER visits<br>• The practice identifies vulnerable patient populations<br>• The practice demonstrates improved performance |

## Appendix B: State-based PCMH Standards

Twenty-seven states have Patient-Centered Medical Home programs tied to payment. Several of these states have multiple programs including states with Health Home initiatives. Among the twenty-seven:

- Twenty-four states recognize or require NCQA PCMH implementation to meet program goals. Of those twenty-four, nine explicitly mandate NCQA recognition. The remaining fifteen states recognize NCQA PCMH but also recognize other PCMH programs.
- Three states – Arkansas, Minnesota and Oklahoma – require their state-developed PCMH program, with no option for alternative recognition processes. However, these models contain significant elements of the nationally-recognized medical home principles.
- Of the twenty-four states that recognize or require NCQA PCMH, three states require practices to submit additional information to fulfill state-specified standards (Oregon, Maine and Massachusetts).

**Closer Look at Program Requirements:**

State programs with additional requirements are based on principles included in the fundamental concept of the patient-centered medical home model. These requirements vary in structure and form from existing national recognition programs but share many of the same goals. Common themes among additional requirements include reporting on state-specific measures and emphasis on robust behavioral health integration. Below are key areas of emphasis states are requiring of their medical home programs.

1. **Expanded access**
    a. 24 hour provider accessibility (IA, MA, MI, MN, NE, NY, OK)
    b. Same-day services as appropriate (IA, NE, OK, OR)
2. **Information systems**
    a. Use health information technology/EHR (IA, ME, MA, MI, MN, NE, NY, OH, OK, OR, WI)
    b. Data/population health management (IA, ME, MA, MI, MN, NE, NY, OR)
3. **Track and coordinate care**
    a. Care coordination across settings, including follow-ups, test and referral tracking (IA, ME, MA, MI, MN, NE, OK, OR, WI)
    b. Team-based approach to care (IA, ME, MA, NE, OK, OR)
    c. Designated care coordinator/care management staff (IA, ME, MA, MN, NE, OR)
4. **Patient-centeredness**
    a. Self-care/self-management support (IA, ME, MA, MI, MN, NE, OK, OR)
    b. Comprehensive patient evaluations and/or personal treatment plans (IA, MI, MN, NE, OK, OR)
    c. Behavioral health integration (IA, ME, MA, OH, OK, OR, WI)*
5. **Performance reporting/quality improvement**
    a. Reduce spending/preventable utilization (ME, MN, NE, NY, OR)
    b. Clinical quality measurement reporting/improvement (IA, MI, MN, NE, OR, WI)