Seema Verma, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
7500 Security Boulevard
Baltimore, MD 21244
ATTENTION: CMS-5522-P

Dear Administrator Verma:

The National Committee for Quality Assurance (NCQA) thanks you for the opportunity to comment on the proposed 2018 Quality Payment Program rule. We applaud you for continuing to transition to paying clinicians for the value, rather than volume, of care provided. NCQA is committed to working with you and other stakeholders to support clinicians throughout this essential transformation.

We are particularly enthusiastic about Virtual Group implementation for 2018. This is a key step toward helping small practices advance toward accountable, team-based, patient-centered care models. NCQA Patient-Centered Medical Homes (PCMHs) and Patient-Centered Specialty Practices (PCSPs) have demonstrated commitment to improving cost and quality and therefore make ideal virtual group partners.[1] We look forward to exploring how NCQA can support CMS and clinicians in creating Virtual Groups. We urge you to provide bonus points as incentive for clinicians to join Virtual Groups. We also urge you to encourage, rather than prohibit, low-volume clinicians' participation in Virtual Groups.

We are pleased that you propose NCQA's Patient-Centered Connected Care (PCCC) Program as an Improvement Activity in the Merit-Based Incentive Payment System (MIPS), with Advancing Care Information (ACI) credit for its use of Health IT. However, PCCC deserves High-weighted Improvement Activity status given the program's focus on care coordination, evidence-based decision support, expanded access and culturally and linguistically appropriate services.

As with PCCC, we believe you should also provide Advancing Care Information auto-credit to PCMHs and PCSPs because of the strong focus on use of Health IT in standards for these programs. ACI auto-credit would reduce unnecessary burden for clinicians who have already completed the rigorous PCMH or PCSP recognition process. Appendices A & B crosswalk the substantial overlap between Health IT provisions in NCQA PCMH and PCSP standards and ACI requirements and measures.

We further believe you need a more comprehensive approach to determining which measures are topped out. Currently, clinicians choose which measures they report and how they report them. This voluntary reporting may lead clinicians to "cherry pick," reporting only measures on which they perform best or only on a sample of the relevant population. An accurate picture of topped out measures requires more universal data collection with mandatory reporting on a clinician's entire population.

Detailed comments on these and other issues in the proposed rule are below.

[1] http://www.ncqa.org/programs/recognition/practices/pcmh-evidence

MIPS Performance Threshold: We support the proposal to establish a 15-point threshold for avoiding performance penalties for CY 2018. However, we urge you to increase the threshold in future years to ensure there are appropriate incentives for clinicians to improve performance on MIPS measures.

Improvement Activities: We support maintaining the 90-day reporting requirement for Improvement Activities. Since NCQA requires that practices seeking PCMH and PCSP Recognition perform the appropriate activities for a minimum of 90 days, CMS should offer full auto-credit to any practice that achieves NCQA Recognition by December 31 of a given performance year. This policy should extend to any other approved PCMH programs that use a 90-day lookback period. This policy should not apply to any PCMH program without a 90-day lookback period.

We support requiring that 50% of NPIs within a TIN have PCMH or PCSP Recognition to get full auto-credit for Improvement Activities, rather than just one as under current rules. However, we urge CMS to accept data feeds from accrediting bodies so that you can move to requiring 100% recognition and ensure that no one gets unearned PCMH or PCSP credit without being in a Recognized practice.

For groups to earn credit for an individual Improvement Activity, we support the proposal to raise the threshold from just one clinician to 50% of NPIs within a TIN performing that activity for all clinicians within the TIN to get credit. You may alternatively want to consider equating this threshold with the credit received. For example, if 70% of the NPIs within a TIN are performing an Improvement Activity, then that group should get 70% credit toward that Improvement Activity score. This will eliminate any incentive to not get additional members of a TIN to work on an Improvement Activity once 50% of clinicians within a TIN are performing it. There also is precedent for this from the Medicare Advantage Star Measures program, where CMS removed 4-Star thresholds that were discouraging further improvement once plans met the thresholds.

Virtual Groups: As stated above, we strongly support Virtual Groups and believe bonus points could encourage Virtual Group participation. You should encourage rather than prohibit low-volume practices' participation in Virtual Groups. We further encourage you to explore development of a test to determine in advance if a Virtual Group will likely have sufficient numbers for valid measurement. After all, a primary purpose of Virtual Groups is to ensure sufficient numbers for valid measurement. We also believe CMS should offer bonus points to incentivize clinicians in small and rural practices to join a Virtual Group and begin moving down the path toward joint accountability. Additionally, we believe at least 50% of clinicians in a Virtual Group should have PCMH or PCSP Recognition for the group to receive full auto-credit for MIPS Improvement Activities.

Quality Measure Data Completeness: We support the proposal to raise the measure data completeness requirement to at least 50% of all eligible patients per measure, and urge you to consider raising it further to 60% for CY 2018 and continuing to raise that threshold over time. As outlined above, reporting on 100% of eligible patients is critical to identification of topped out measures and prevention of gaming. Mandatory reporting of core population-based measure sets would demonstrate where there is actual limited performance variability above 95%, rather than just skewed reporting. For example, Medication Reconciliation in PQRS consistently produces rates above 95%. However, the same plan-level measure in HEDIS (where its reporting is mandatory) has a performance rate of about 46%.

Improvement Points: We strongly support offering improvement points, but believe it is essential to only score improvement on the same measures using the same reporting mechanism year-to-year. Allowing clinicians to switch between measures and reporting mechanisms begs for gaming.

Cost: We believe you should raise the weight for this category from 0% to 10%. Clinicians must become accustomed to being measured and held accountable for costs so they can implement the appropriate infrastructure and processes to succeed on these measures.

Reporting Mechanisms: We support providing flexibility for clinicians to submit data through as many mechanisms as necessary for all categories. However, we urge you to develop a transition plan to move toward only accepting data from electronic systems that have demonstrated abilities to produce valid measurement data, such as those EHRs that have achieved NCQA eMeasure Certification. This is key to ensuring that Medicare is paying bonuses and penalties based on the most valid, reliable data available.

Third Party Data Intermediaries: We agree that CMS should incentivize clinicians to use multi-payer third party data intermediaries. However, these intermediaries must be certified and audited to confirm data completeness. Our experience with testing health IT vendors' ability to produce accurate results as part of the NCQA eMeasure Certification program, as well as CMS' own reporting, indicate that more robust and stringent testing of health IT systems measure reporting functionality is necessary to ensure that payments tied to quality measures are based on accurate, reliable, and verifiable data.

Risk Adjustment: We do not support risk adjusting quality measures for factors such as socioeconomic status. Rather, we support stratifying measure results to identify and highlight disparities. CMS can then address those disparities by adjusting payment or offering bonus points to clinicians who see patients with a disproportionately high rate of disparities in care. We also support offering up to three bonus points using clinicians' mean HCC risk score as well as providing bonus points based on the percentage of a clinician's caseload of patients who are dually eligible for Medicare and Medicaid.

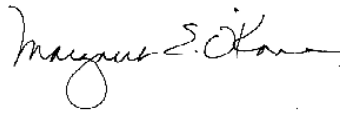
Bonus Points: The proposal offers bonus points to small practices, defined as 15 or fewer clinicians. We believe you should only offer bonus points to clinicians in truly small practices, defined as five or fewer clinicians. We believe a more modest bonus for rural practices may be appropriate, as well. We support the proposal to offer bonus points to clinicians who use 2015 Edition CEHRT.

Alternative Payment Models: We support a lower nominal risk standard for small practices participating in Advanced Alternative Payment Models (APMs). However, we encourage you to raise the bar for all APM participants over time to encourage movement toward truly population-based payment.

We also support aligning the nominal risk standard for Other Payer APMs with that of Medicare APMs. We support requiring Other Payer APM participants to report at least one outcome measure if available. However, we encourage you to require at least 75% of APM participants to use CEHRT.

Thank you again for inviting our comments. If you have any questions about our thoughts, please contact Paul Cotton, Director of Federal Affairs, at cotton@ncqa.org or (202) 955-5162.

Sincerely,



Margaret O'Kane,
President

Appendix A
Advancing Care Information & NCQA PCMH

Advancing Care Information Measure	NCQA PCMH Standard
Security Risk Analysis	***Team-Based Care & Practice Organization*** - Standard 5: The practice uses an EHR system (or modules) that has been certified and issued an ONC Certification ID, conducts a security risk analysis, and implements security updates as necessary correcting identified security deficiencies.
e-Prescribing	***Knowing and Managing Your Patients*** - Standard 19: Systematically obtains prescription claims data in order to assess and address medication adherence.
Provide Patient Access	***Patient-Centered Access and Continuity*** - Standard 5: Documents clinical advice in patient records and confirms clinical advice and care provided after-hours does not conflict with patient medical record. - Standard 7: Has a secure electronic system for patient to request appointments, prescription refills, referrals and test results.
Send a Summary of Care	***Care Coordination and Care Transitions*** - Standard 4 (A-C): The practice systematically manages referrals by: A. Giving the consultant or specialist the clinical question, the required timing and the type of referral; B. Giving the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan; C. Tracking referrals until the consultant or specialist's report is available, flagging and following up on overdue reports. - Standard 15: Shares clinical information with admitting hospitals and emergency departments. - Standard 18: Exchanges patient information with the hospital during a patient's hospitalization. - Standard 21 (C): Demonstrates electronic exchange of information with external entities, agencies and registries: C. Summary of care record to another provider or care facility for care transitions.

Advancing Care Information Measure	**NCQA PCMH Standard**
Request/Accept Summary of Care	***Care Coordination and Care Transitions*** - Standard 18: Exchanges patient information with the hospital during a patient's hospitalization. - Standard 19: Implements a process to consistently obtain patient discharge summaries from the hospital and other facilities. - Standard 21 (C): Demonstrates electronic exchange of information with external entities, agencies and registries: C. Summary of care record to another provider or care facility for care transitions.
Patient-Specific Education	***Knowing and Managing Your Patients*** - Standard 8: Evaluates patient population demographics/communication preferences/health literacy to tailor development and distribution of patient materials. - Standard 16: Assesses understanding and provides education, as needed, on new prescriptions for more than 50 percent of patients/families/caregiver. - Standard 21: Uses information on the population served by the practice to prioritize needed community resources. - Standard 22: Provides access to educational resources, such as materials, peer-support sessions, group classes, online self-management tools or programs.
View, Download and Transmit (VDT)	***Patient-Centered Access and Continuity*** - Standard 5: Documents clinical advice in patient records and confirms clinical advice and care provided after-hours does not conflict with patient medical record. - Standard 7: Has a secure electronic system for patient to request appointments, prescription refills, referrals and test results.
Secure Messaging	***Patient-Centered Access and Continuity*** - Standard 5: Documents clinical advice in patient records and confirms clinical advice and care provided after-hours does not conflict with patient medical record. - Standard 8: Has a secure electronic system for two-way communication to provide timely clinical advice.

Advancing Care Information Measure	**NCQA PCMH Standard**
Patient-Generated Health Data	***Care Management and Support*** - Standard 7: Identifies and discusses potential barriers to meeting goals in individual care plans. - Standard 8: Includes a self-management plan in individual care plans. - Standard 9: Care plan is integrated and accessible across settings of care.
Clinical Information Reconciliation	***Knowing and Managing Your Patients*** - Standard 14: Reviews and reconciles medications for more than 80 percent of patients received from care transitions. ***Care Coordination and Care Transitions*** - Standard 20: Collaborates with the patient/family/caregiver to develop/implement a written care plan for complex patients transitioning into/out of the practice (e.g., from pediatric care to adult care).
Immunization Registry Reporting	***Care Coordination and Care Transitions*** - Standard 21 (B): Demonstrates electronic exchange of information with external entities, agencies and registries: B. Immunization registries or immunization information systems.

Appendix B
Advancing Care Information & NCQA PCSP

Advancing Care Information Measure	NCQA PCSP Domain & Element
Security Risk Analysis	***Measure and Improve Performance*** - Element E: Use Certified EHR Technology. The practice uses a certified EHR system: o The practice attests to conducting a security risk analysis of its EHR system (or modules) and implementing security updates as necessary and correcting identified security deficiencies.
e-Prescribing	***Plan and Manage Care*** - Element C: Use Electronic Prescribing. The practice uses an electronic prescription system with the following capabilities: o At least 75 percent of eligible prescriptions are generated using the electronic prescription system. o More than 50 percent of eligible prescriptions written by the practice are compared to drug formularies and sent to pharmacies electronically. o More than 60 percent of medication orders are entered into the medical record.
Provide Patient Access	***Provide Access and Communication*** - Element B: Electronic Access. The practice provides the following information and services to patients/ families/caregivers through a secure electronic system: o More than 50 percent of patients have timely access to their health information. o The capability to view, download or transmit their health information to a third party.

Advancing Care Information Measure	**NCQA PCSP Domain & Element**
Send a Summary of Care	***Working with Primary Care and Other Referring Clinicians*** - Element D: Assessing Initial Referral Response. The practice has a written process and monitors against it to ensure a timely response to PCPs and referring clinicians that includes: o Electronic transmission of a summary of care record to another provider, for more than 10 percent of referrals. - Element F: Connecting Patients With Primary Care. The practice implements a documented process for connecting self-referred patients with primary care clinicians that includes: o For self-referred patients with a primary care clinician, providing a summary of care report to the primary care clinician. ***Track and Coordinate Care*** - Element B: Referral Tracking and Follow-Up. The practice coordinates referrals to other (secondary) specialists by: o Demonstrating its capability to provide an electronic summary-of-care record to another provider following a referral. o Electronically transmitting a summary-of-care record to another care provider, for more than 10 percent of care referrals. - Element C: Coordinate Care Transitions. The practice supports patients who have an ongoing relationship with a specialist during acute care transitions. For these patients, the practice systematically: o Demonstrates its capability to provide an electronic summary of care record to another facility following a transition of care. o Electronically transmits a summary of care record to another care setting for more than 10 percent of care transitions.

Advancing Care Information Measure	**NCQA PCSP Domain & Element**
Request/Accept Summary of Care	***Track and Coordinate Care*** - Element B: Referral Tracking and Follow-Up. The practice coordinates referrals to other (secondary) specialists by: o Following up to obtain the specialist's report. o Asking patients/families/caregivers about self-referrals and requesting reports from clinicians. - Element C: Coordinate Care Transitions. The practice supports patients who have an ongoing relationship with a specialist during acute care transitions. For these patients, the practice systematically: o Demonstrates its process for consistently obtaining patient discharge summaries from the hospital and other facilities.
Patient-Specific Education	***Plan and Manage Care*** - Element A: Care Planning and Support Self-Care. The practice provides the following care management and self-care support for practice-specific conditions: o Uses an EHR to identify and provide patient-specific education resources to more than 10 percent of patients.
View, Download and Transmit (VDT)	***Provide Access and Communication*** - Element B: Electronic Access. The practice provides the following information and services to patients/ families/caregivers through a secure electronic system: o More than 50 percent of patients have timely access to their health information. o The capability to view, download or transmit their health information to a third party.
Secure Messaging	***Provide Access and Communication*** - Element B: Electronic Access. The practice provides the following information and services to patients/ families/caregivers through a secure electronic system: o The capability to send a secure message. o Two-way communication between patients/families/caregivers and the practice. o Requests for appointments, prescription refills, referrals and test results.

Advancing Care Information Measure	**NCQA PCSP Domain & Element**
Patient-Generated Health Data	***No analogous standard at this time.*** - With approval from CMS, we can develop this as a part of an ACI deeming module for PCSP.
Clinical Information Reconciliation	***Plan and Manage Care*** - Element B: Medication Management. The practice has a process and demonstrates that it systematically manages medications prescribed by the practice in the following ways: o Reconciles medications for more than 50 percent of patients received from another care setting or at a relevant visit. ***Working With Primary Care and Other Referring Clinicians*** - Element C: Assessing Initial Referral Content. The practice sets expectations and monitors against those expectations to confirm receipt of information needed in referrals from clinicians: o Clinical questions to be answered by the referral. o Type of referral. o Urgency of referral. o Patient demographics. o Clinical information. o Current primary practice care plan, treatment, test results and procedures. o Which clinician is responsible for communicating with patient/family/ caregiver.
Immunization Registry Reporting	***Measure and Improve Performance*** - Element E: Use Certified EHR Technology. The practice uses a certified EHR system: o The practice demonstrates the capability to submit electronic data to immunization registries or immunization information systems.