



June 21, 2016

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
7500 Security Boulevard
Baltimore, MD 21244

ATTENTION: CMS-5517-P

Dear Acting Administrator Slavitt:

Thank you for the opportunity to comment on the Medicare Access & CHIP Reauthorization Act's (MACRA) Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) rule you proposed. The National Committee for Quality Assurance (NCQA) strongly supports this transition to paying clinicians for the value, rather than volume, of care they provide, and is eager to help.

The highest priority in implementing MACRA is to help clinicians advance from traditional practices into Patient-Centered Medical Homes (PCMHs) and Patient-Centered Specialty Practices (PCSPs), virtual groups and ultimately Alternative Payment Models. Each step along this continuum increases clinicians' potential to improve and achieve MACRA's goals and financial rewards. All stakeholders share a joint responsibility to support clinicians as they work to move up this continuum. We also must strive for fair comparisons among clinicians across different payment models. We at NCQA are committed to working and aligning with other stakeholders in this essential transformative endeavor.

Several provisions in the proposed rule will help, and we particularly strongly support:

- Requiring PCMH and PCSP recognition from a national-in-scope, widely used third party program to receive automatic full Clinical Practice Improvement Activity (CPIA) credit.
- Working toward more and better outcome measurement and measures derived from data entered into electronic systems as a natural part of clinical workflow.
- Offering bonus points for electronic reporting and reporting in high priority areas.
- Promoting joint accountability by averaging MIPS scores among each APM's participants and applying that average score to each participant.
- Setting an appropriately high bar for "Advanced" APMs that earn automatic 5% bonuses.

We are concerned, however, that the proposed rule would:

- Establish insufficient criteria for identifying and including quality measures for reporting in MIPS.
- Unwisely threaten small practices' viability and their patients' access to care by comparing them to larger practices with greater abilities to administer improvement programs and earn bonuses.
- Undermine AAPM viability by basing "nominal risk" on total care cost rather than Medicare revenue.
- Not support Medicare Advantage and other health plans' potential to facilitate AAPM Entities.

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

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

We generally support your proposals for MIPS, which adjusts fee-for-service pay based on:

- Quality, which assesses clinical care.
- Resource Use, which assesses efficiency.
- Clinical Practice Improvement Activities, which should improve outcomes if effectively implemented.
- Advancing Care Information, which assesses use of health information technology to improve care.

However, given MIPS' complexity and wide variation in clinician readiness, you may want to simplify the requirements.

Quality Reporting: We appreciate your interest in helping clinicians adjust to MACRA by initially lowering the threshold for the minimum number of measures they must report from the current nine to just six. However, this lower threshold will provide a diminished picture of quality overall while increasing clinicians' ability to game the system by reporting only measures on which they do well. We therefore urge you to consider creating core sets of measures for primary care and specialists that will encourage all providers to report on a parsimonious unified set of quality measures. We participated in the Core Quality Measures Collaborative that released proposed core measure sets earlier this year, and believe such core measure sets are essential for comparing clinicians across payment models. However, it is also essential that core measure sets evolve, and that additional measures be available when needed for meeting the needs of specific populations, such as vulnerable patients.

We also encourage you to closely monitor for specialties where significant numbers of clinicians report less than the minimum number to help focus measure development on filling any related measurement gaps. And we support your proposal to develop a validation process, and then give scores of zero, if clinicians can, but fail to, report on the minimum number of measures.

Measure Criteria: We are very concerned that the proposed rule sets inadequate quality measure criteria. The proposed rule would merely require measures to be evidence-based, reliable and valid. This low bar would give clinicians credit for reporting on measures that do not advance MACRA's goals and create great potential for gaming. Also, specialties with the fewest measures often have the weakest evidence base, which limits their ability to develop measures.

To provide real value and meet MACRA's goals, measures must also be clinically important, transparent, feasible, actionable and rigorously audited to ensure accuracy and fairness. There is no point to measures that are not clinically important to health care consumers and the system overall. There is great potential for gaming if measures are not publicly transparent on what is being measured and how. There is little ability to report measures for which it is not feasible to collect and validate the data. There is no point to measures that are not actionable in promptly showing where clinicians must improve. And rigorous auditing is essential to ensuring real quality improvement and honest reporting.

Gaming: We share concerns about gaming. For example, clinicians could report measures with insufficient sample sizes to decrease the quality category's weight, or only measures they do well on. Also, specialties with few measures often have weak evidence bases that limit the ability to promptly fill measurement gaps. You could address this by establishing a floor for the quality category's weight to prevent gaming by not having enough measures to report.

All-Payer Data: One of MACRA's most important themes is its move toward assessing not just Medicare, but all payers' patients in APMs. To best support this and ensure data completeness when clinicians in APMs report on non-Medicare patients for MIPS, we encourage you to move away from the traditional visit-based measurement. Instead, you should focus more on assessing outcomes for a whole population. For example, many measures look for documentation of a follow-up plan. Population-based assessment would look for whether follow-up actually occurred and whether the outcome or symptom was re-assessed after follow-up. This approach would encourage and reward clinicians for providing and coordinating care across the continuum of a condition rather than a single encounter. However, we note that population-based assessment is difficult without prospective enrollment that informs clinicians in advance about the patients for which they are accountable. The ability to improve on population health measures therefore is limited in MIPS.

Bonus Points: We support providing bonus points for reporting in high priority areas. These include outcome and patient experience measures, as well as other high priority measures on patient safety, efficiency, appropriate use and care coordination. It also may encourage reporting on more than the minimum number of six measures.

Providing bonus points for electronic reporting is especially important, as it will help move to a future state where measurement is based on electronic data derived as a part of, not in addition to, normal clinical workflows. This electronic reporting should be through systems certified to produce accurate and reliable electronic quality measure results. We encourage you to also consider providing bonus points to incentivize clinicians to aggregate into virtual groups. We further support capping the number of bonus points so they do not mask low quality in other areas.

Readmission Measurement: We recommend using NCQA's All-Cause Readmissions measure (NQF #1768), that is specified for populations and thus useful for comparing MIPS clinicians overall to APMs, but not for assessing individual MIPS clinicians. The All-Cause Hospital Readmission Measure (NQF #1789) you propose is specified for hospitals and not appropriate for assessing MIPS clinicians individually or overall. NQF #1768 also includes a wider age span and all acute hospitalizations, including psychiatric and cancer hospitalizations. NQF #1768 further promotes multi-player and cross-program alignment as it is also used in the Medicare Advantage Stars Rating program, Medicaid Adult Core Set and NCQA's leading health plan accreditation program covering over 224 million American lives. Alignment across these measure sets will reduce provider burden and support comparison across MIPS, Medicare Advantage, Medicaid and large numbers of commercial plans.

Consumer Assessment of Healthcare Providers & Systems: Patient experience reporting for groups of >100 should eventually be mandatory. However, we support voluntary reporting until the survey and its reporting mechanism improve. The current CAHPS survey is too long and generates low response rates. It also does not provide the prompt, targeted feedback clinicians need. Our own psychometric testing suggests it could be cut by at least one third, as answers to many questions consistently predict answers to others. We also believe that electronic alternatives to the paper-and-mail-based survey administration process could increase both response and feedback rates. We therefore urge you to work with clinicians, Agency for Healthcare Research & Quality CAHPS stewards and other stakeholders to develop a better means of obtaining patient experience data and require its use as soon as feasible. Ideally, this improved tool will have better data systems and standardized collection methods that support inclusion of other payers' patients in CAHPS samples. For incorporating other payers' patient experience data, CMS should establish standardized methods for drawing samples, validating that logic and auditing to ensure the logic is applied to the full eligible population.

Behavioral Health Measures: In addition to the measurement priorities you identify, we strongly urge you to also prioritize behavioral health and include more behavioral health measures. Behavioral conditions are substantially undertreated and strongly associated with greater use of other health care services and higher costs. Treatments for many behavioral health conditions also have significant side effects that require careful monitoring and often further treatment. Furthermore, there is often little if any of the coordination between behavioral and other health care providers that is needed for optimal care.

There has been minimal progress on existing behavioral measures, and NCQA is aggressively working to address that and fill gaps in behavioral measurement. Appendix A lists nearly 30 behavioral measures we have or are now developing. We encourage you to consider including them in MIPS when they can be applied appropriately and fairly to hold clinicians accountable in order to drive much-needed improvement in this critical area. We further encourage you to provide bonus points to incentivize reporting on them.

Appropriate Use: You ask in the proposed rule what measures to include for appropriate use. NCQA's Healthcare Effectiveness Data & Information Set (HEDIS[®]) includes several measures that will be effective in assessing appropriate use. For example, HEDIS measure include:

- Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis;
- Non-Recommended PSA-Based Screening in Older Men; and
- Use of Imaging Studies for Low Back Pain.

Two additional HEDIS measures can assess appropriate use at population or group levels. However, they are not appropriate for individual practitioners who cannot be accountable for prescriptions by other practitioners. These are:

- Use of High-Risk Medications in the Elderly; and
- Potentially Harmful Drug-Disease Interactions in the Elderly.

However, appropriate use measures face key challenges that require broader understanding.

- There is a narrow range of procedures and tests for which there is broad stakeholder consensus that a procedure can represent inappropriate care. In many areas, we simply lack the evidence base to state that a given intervention constitutes overuse.
- Overuse measures must account for symptoms and history that make an otherwise questionable service appropriate for individuals. However, information on whether individual patients have such factors often is not in claims and requires extensive medical record review, at least until measurement derives from electronic health records. Even then, once all appropriate exclusions are identified, the number of cases that can be confidently categorized as overuse can be quite small.
- Skewed payments can trump overuse measures, especially for overvalued specialty services. Overuse measures – no matter how good – will have minimal impact if overvalued payments reward more services and complex care. Efforts to reduce over-valued codes, arbitrary percentage-based add-on payments for drugs and promote payment reforms that reward quality and efficiency are advancing, yet much more needs to be done.
- Assigning accountability for appropriate use measures is challenging when more than one provider may be responsible for inappropriate care. As discussed above, measurement of high-risk medication use should include all prescribed medications, not just those from a single practitioner, and it is not reasonable to hold an individual practitioner accountable for medications prescribed by another practitioner.

We therefore urge you to use the HEDIS measures described above, work to develop better evidence and electronic data systems needed for additional appropriate use measures, and continue your ongoing efforts to address skewed payments that can trump over use measures.

Hospital-Employed Clinicians: Allowing hospital-employed clinicians to choose hospital measures is appropriate for some, such as hospitalists whose performance is closely linked with their facility's. It would not be appropriate for others, such as clinicians in outpatient clinics or surgeons, who should be required to report other MIPS measures more specific to their own individual practice.

Future Measurement & Moving to Outcomes: The proposed rule takes appropriate, measured steps in moving performance assessment from assessing processes to instead evaluate outcomes. The focus on patient-reported outcomes measures (PROMs) is particularly helpful, as PROMs are among the best ways to measure outcomes and are well understood by patients when publicly reported. PROMs also have great utility in helping clinicians manage individual patients. For example, the depression measure based on the PHQ-9 screening tool can help clinicians track whether prescribed treatments are working or need adjustment.

However, there are important challenges to address in getting to better outcomes measures. Measurement today is largely based on claims that lack data outcomes. Measurement that derives from data entered into electronic systems as a natural part of clinical workflow will enable better outcomes measurement and reduce the burden required for measurement reporting. CMS should encourage electronic health record (EHR) vendors to incorporate PROMs, as well as development and use of PROMs, while carefully monitoring their use for potential gaming, such as copy-and-paste documentation. Also, it is difficult for clinicians in small practices or other minimally organized systems to have substantial impact on outcomes, which are influenced by many factors beyond clinical care. MACRA addresses this by encouraging clinicians to move toward APMs for which population-based outcomes assessment is more fair.

The best outcome measures will combine the individual person's goals, preferences, needs and health conditions with solid scientific evidence. These will help us move beyond blunt thresholds based on the general population to instead focus on thresholds that optimize care for individuals.

One example is the Global Cardiovascular Risk (GCVR), a predictive model that creates cardiovascular disease risk scores from patient data in electronic systems. Rather than focusing on population-based targets (e.g., blood pressure of 140/90, A1c of 9.0) GCVR acknowledges that the greatest benefit for one individual may be smoking cessation and for another may be bringing systolic blood pressure of 200 down to 150. The foundation of GCVR scores is that they are sensitive to changes in individual patients' risk profile, rather than achievement of static thresholds. The system uses electronic clinical data to gauge which care elements would register the most significant impact on outcomes for the individual patient.

Giving patients an active voice in selecting treatment goals also addresses a critical gap in improving outcomes. Using large electronic clinical data systems and innovative, whole-person quality measures such as GCVR will increase the accuracy, efficiency and timeliness of information needed to customize and improve care for individual patients.

Measures for Duals & Other Complex Populations: We support adding the Medicaid Adult Core Set to MIPS, which is particularly important for people dually enrolled in Medicare and Medicaid who have greater need and higher costs.

We also are working on a suite of measures that use PROMs to assess how well care helps individual patients meet their own goals, which may not necessarily be clinical. This method assesses a patient's progress on standardized outcomes associated with their goals, such as being more active or able to participate socially, and is discussed in detail in our previous comments on the draft [MACRA Measure Development Plan](#).

Resource Use: We agree that resource use is an integral part of value. We also appreciate your interest in starting with existing condition and episode-based measures, and the total per capita costs for all attributed beneficiaries measure (total per capita cost measure). We strongly endorse your plan to incorporate new measures as they become available, and look forward to working with you and other stakeholders to further advance and refine resource use measurement. We support adjusting both of the resource use measures for beneficiary risk factors and adjusting the total per capita cost measure for specialty. However, we do not support adjustment for the many geographic resource use differences not related to beneficiary risk, which represent inefficiencies that harm both costs and sometimes patient health.

Socio-Economic Status: We appreciate your interest in this area and also eagerly await the HHS Assistant Secretary for Planning and Evaluation's study on this topic. Our own research shows that while there is a correlation between SES and quality, it is small and many positive outliers achieve high quality despite serving low SES populations. The correlation between SES and resource use is much clearer, as meeting lower SES patients' greater needs and challenges costs more, for example in care coordination supported by care management fees. This is why Medicare is now adjusting payments to Medicare Advantage plans to account for the higher costs of serving low-SES enrollees who are dually eligible for Medicare and Medicaid. We therefore support risk adjusting resource use measures for SES because there is a clear and plausible association between SES and care costs. We oppose risk adjusting quality measures where SES associations are at best murky.

Clinical Practice Improvement Activities (CPIAs): We especially appreciate the proposed rule's recognition of the need for independent validation of Patient-Centered Medical Homes (PCMHs) and Patient-Centered Specialty Practices (PCSPs). Third-party validation is critical given that PCMHs and PCSPs get full CPIA credit, CMS lacks resources to verify PCMH or PCSP status and simple attestation allows no meaningful assurance that practices provide essential PCMH and PCSP services.

NCQA's PCMH program is by far the nation's largest, with over 17% of all primary care physicians and more than 56,600 clinicians overall at over 11,420 sites across the country. Our PCSP program is the only such program that currently exists for specialists. Our PCMH and PCSP programs together help clinicians build well-coordinated "medical neighborhoods" that are ideal AAPM foundations. To earn NCQA recognition practices must meet high standards for expanded access, care coordination, population management, and helping patients to better engage in their own health and health care. The programs strongly support Congressional intent to promote high quality, efficient patient-centered care.

For other PCMH and PCSP programs to similarly qualify clinicians for auto-CPIA credit, we support your proposed criteria that they must be both "national in scope" and "widely used." The next largest PCMH program after ours has only around 1,300 recognized practice sites, and some have far fewer.

We encourage you to establish specific thresholds for assessing which programs meet those criteria and to require up-to-date market penetration data to verify whether other programs meet those thresholds.

In considering criteria for awarding CPIA auto-credit to clinicians in recognized PCMHs and PCSPs, we note that practices must show us that they have been meeting our standards for at least three months prior to formal recognition. CMS should apply the standard established in the proposed rule for receiving credit for individual CPIAs (at least 90 days in a given performance year) to the auto-credit provision. For NCQA-recognized practices, this would mean practices recognized at any point in a year would receive automatic, full CPIA credit for that year, since they will have been operating at the level of a recognized PCMH for at least 90 days.

Regarding how to assign PCMH credit when only some practices using the same tax identification number (TIN) have recognition, we note that some practices have more than one TIN and some clinicians practice in more than one site under different TINs. We are asking our PCMH and PCSP practices how you might address this challenge and will share any insights from them with you.

Individual Clinical Practice Improvement Activities: Outside of independently recognized PCMHs and PCSPs, it will be critical to verify, and not merely accept attestation, that clinicians perform individual activities to earn points for CPIA credit. Attestation invites gaming and provides little if any ability to verify whether CPIAs are actually implemented, which is essential for securing real change. We therefore strongly support your proposal to include CMS' ability to validate among criteria for any new CPIAs, and are eager to help. For example, NCQA can provide data feeds for practices that have begun but not yet completed NCQA's recognition process on individual CPIAs they have documented to us.

We also support your proposal to study simpler ways to collect and verify CPIAs and provide more rapid feedback, and are eager to help in any way we can. We further support Achieving Health Equity, Integrated Behavioral and Mental Health, Promoting Health Equity and Continuity and Social and Community Involvement CPIA subcategories. In refining individual CPIAs over time, we encourage you to focus on those that are most effective in helping clinicians advance towards APMs.

APM Clinicians in MIPS: For clinicians in APMs being assessed under MIPS, their status as APM participants that provides 50% of the CPIA score is automatically validated. We strongly support the proposal to average scores for all clinicians in an APM and apply that average to all clinicians in the APM for determining MIPS payment adjustments. This will promote joint accountability within APMs. For the same reasons, we support aggregating data across all clinicians who choose to report as a group so they are scored as a group for all MIPS categories.

Advancing Care Information: We support the proposal to assess clinicians progress in using EHRs to improve care and move away from blunt thresholds. Over time, we urge you to gradually reduce the "base score" for simply reporting on EHR use and to increase the "performance score" in order to encourage further progress.

We support requiring clinicians to cooperate with ONC's EHR field surveillance and consistently exchange data regardless of health system affiliation or EHR vendors. This is urgently needed to ensure that electronic data systems function effectively and to stop data blocking that impedes good care coordination across providers and settings. We further support the proposal to reduce clinicians' Advancing Care Information scores to zero for failure to protect privacy, which must be paramount.

We also strongly favor your proposal to define success in this category as achieving a 75% score, and reduce the category's weight when 75% of clinicians reach that threshold. Reducing the weight when just 50% reach the threshold would prematurely thwart efforts to increase data sharing for care coordination and quality improvement.

Protecting Small Practices: While MACRA's push towards APMs is critical, the proposed rule's disproportionately negative impact on small practices participating in MIPS poses a serious threat to such practices and patients who rely on them. Table 64 in the proposed rule suggests that a large majority of practices with fewer than 25 clinicians will get negative payment adjustments but a large majority of practices with 100 or more clinicians will get bonuses. This is understandable given that larger practices have more ability to administer improvement programs and score well in MIPS.

However, there are many sparsely populated regions that support only small numbers of small practices which may not readily aggregate into virtual groups. Beneficiaries in these regions could lose needed access to care if MIPS makes these practices financially unsustainable. In other areas, pushing too hard and too fast for aggregation could have the unintended consequence of incentivizing practices to join large hospital-based systems that drive higher costs system-wide.

Stratifying practices by their size for MIPS comparison purposes would address these concerns. For example, you could compare practices with <10 clinicians to similarly sized practices, do the same for practices with 10-100 clinicians and the same for practices with 100+ clinicians. Alternatively, you could adjust MIPS payment adjustments for practice size to account for smaller practices' more limited ability to implement improvement programs and protect needed access to care.

ALTERNATIVE PAYMENT MODELS (APMs)

APMs move clinicians farther away from traditional fee-for-service and toward population-based payment with performance-based pay, use of certified EHR technology (CEHRT) and sharing both potential savings or losses. Congress clearly sought to encourage clinicians to move into APMs by providing automatic 5% bonuses to clinicians in APMs that meet specific payment and patient thresholds and then higher annual Medicare fee updates in the out years. APMs have much greater potential for improvement because of their greater ability to implement quality improvement programs, coordinate care across settings and providers, be fairly and clearly held accountable for improvement and be assessed on population measures.

Given this significant incentive, we generally agree with the proposed high bar for earning AAPMs status but believe additional models to those listed in the proposed rule also qualify. However, the proposed definition of "more than nominal risk" required for AAPMs may limit the ability of some clinicians, particularly those in smaller or solo practices, to participate in AAPMs by basing "nominal risk" requirements on total care cost rather than Medicare revenue. We appreciate your concern about calculating the amount of risk based on Medicare revenue alone for each individual practice. However, the work should be minimal since CMS must do this for both the Medical Home Model Standard and to calculate the percent of revenue threshold for determining qualified AAPM Entities. Given the benefit and incremental work required, we strongly urge you to base the standard nominal risk model on Medicare revenue, as you propose for the Medical Home Model.

Given APMs' greater potential to improve, CMS and the Physician-Focused Payment Advisory Committee need to develop clear paths for bringing clinicians into APMs. We therefore urge you to provide more specifics about how to apply and qualify for AAPM status. We also encourage you to increase APM measure requirements over time to reflect their greater potential to improve, and to require them to report on critically important behavioral measures whenever relevant.

Our comments and suggestions on specific APM proposals and comment requests are below.

AAPMs: While we support a high bar for AAPMs, similar as well as additional models to those named in the proposed rule should qualify. For example, since the Comprehensive Primary Care Plus (CPC+) model is proposed as an AAPM, APMs that meet the same CPC+ participation and payment criteria should also be AAPMs. The Bundled Payments for Care Improvement Initiative Models 2 and 4 that include prospective bundling and two-sided risk similarly should qualify as AAPMs. Existing private sector APMs using PCMHs or bundled payments should get priority consideration for meeting AAPM criteria. Given that proposed AAPMs are time-limited demonstrations, we urge you to clarify what becomes of clinicians in these demonstrations once the demonstrations end.

Importantly, Medicare Advantage and other health plans could facilitate APM Entities through their networks. Health plans bear risk and increasingly compensate clinicians as APMs do. Health plans also often purchase stop-loss coverage which could cover clinicians' APM risk. Letting Medicare Advantage and other health plans facilitate APM Entities thus could increase the number of clinicians able to bear AAPM-level nominal risk. It further could increase the number of clinicians able to meet AAPM thresholds by including plans' patients and payments, as well as promote all-payer APM alignment as MACRA envisions.

More than Nominal Risk: You should not base "more than nominal risk" AAPMs benchmarks on total cost of care as that much risk threatens financial viability. You should instead base benchmarks on APM Entities' Part A and B Medicare revenue to limit the risk and maintain financial viability.

Certified EHR Technology: Initially we support having the same CEHRT definition for Advanced and other APMs. However, going forward it will be important to raise the bar and expect more from AAPMs who will have both the resources and capabilities to achieve greater results. Similarly, proposed thresholds for CEHRT use are initially appropriate, but should increase over time, especially for APMs with above average health IT adoption. We created an e-measure certification program to address gaps in CEHRT quality measure certification and submitted [detailed comments](#) to CMS on the issue.

Interoperability is critical for APMs to succeed. The Office of the National Coordinator therefore should work with APMs and other stakeholders to determine whether additional interoperability requirements and/or standards and criteria for care coordination, population health management and patient engagement might be helpful based on APM's actual experience. Overall, however, health IT requirements will need to evolve to support expanded health information exchange as that expansion, which is now highly uneven across the country, becomes more uniform.

Measures Comparable to MIPS: As to whether to let APMs use all measures comparable to the criteria set for MIPS measures – evidence-based, reliable and valid – we reiterate our belief that MIPS measure criteria are insufficient and must be much more stringent to achieve MACRA's goals. To provide actual value, measures must also be clinically important, transparent, feasible, actionable and rigorously audited to ensure accuracy. There is no point to measures that are not clinically important to health care

consumers and the system overall. There is great potential for gaming if measures are not publicly transparent on what is being measured and how. There is little ability to report measures for which it is not feasible to collect and validate the data. There also is no point to measures that are not actionable in showing where clinicians must improve. And rigorous auditing is essential to ensuring real quality improvement and honest reporting.

Medical Home Models: For Medical Home Model APMs, CMS should require a dedicated primary care team for each individual enrollee. Dedicated primary care teams engage patients and/or family caregivers as partners in their own health and care, support population management and improve quality, cost and experience of care. They also, importantly, mitigate fractured care that makes it exceedingly difficult to assign, or hold clinicians accountable, for the quality of care delivered to individual or groups of patients. Assigning accountability is essential for meaningful and actionable performance-based payment. For Medicaid Medical Home Models, criteria should as much as possible be parallel to those for Medicare.

However, we do not support the proposal to limit Medical Home Model APM's to only practices with 50 or fewer eligible clinicians. This arbitrary limit would prohibit practices with 51 or more clinicians from becoming Qualified Providers for no apparent reason.

Qualified Provider Thresholds: We support the proposed thresholds for whether providers are delivering enough care through the APM to reach specific levels of their revenue and patients to qualify as Advanced or Partial qualified providers in APMs. We urge you to develop a standardized attribution model so all determinations of whether APMs achieve these revenues and patient thresholds are made in a fair and transparent manner.

Other Payer APMs: The ability to include not just Medicare but all payers' patients in APMs is among MACRA's most important provisions. The current cacophony of different measures and payment incentives across payers needlessly increases clinician burden and frustration. It also makes it exceedingly difficult for other stakeholders to make apples-to-apples comparisons across innovative payment models. The standardized attribution model described above will be particularly important for ensuring fairness when including other payers. So will establishment of parallel requirements, such as to have at least one outcome measure for other payer APMs.

HELPING CLINICIANS ADVANCE TOWARDS APMS

MACRA is clearly structured to encourage clinicians to aggregate, share financial risk and work together in large groups that are better able to improve the cost, quality and experience of care. The automatic 5% bonus for Advanced APMs (AAPMs) creates a powerful incentive to do so. MACRA wisely provides wide latitude for clinicians to develop innovative APMs. The statute also includes provisions, such as for virtual groups, that can help clinicians embark on this critical journey. However, clinicians need clear guidance from Medicare on how to proceed.

Virtual Groups: Virtual groups let clinicians join together to have enough patients for valid measurement, and can be a critical first step towards development of more organized systems and ultimately AAPMs. They also may be a significant departure from previous experience for many clinicians. We appreciate CMS' need for additional time to develop a virtual group registration.

However, Medicare should also use this time to encourage and support development of much-needed guidance and assistance on how clinicians can take this first step toward building organized systems that are more capable of improving care and move up the continuum toward APMs. We are eager to collaborate with you and other stakeholders to help clinicians aggregate into virtual groups and begin the journey toward APMs.

We suggest as a start that it might include guidance on:

- Identifying virtual group partners, such as recognized PCMH and/or PCSP practices that MACRA actively promotes. Recognized PCMHs and PCSPs have demonstrated commitments to well-coordinated, high-quality, patient-centered care and thus greater potential to improve MIPS scores. These could be:
 - Other PCMH and PCSP practices in the same community or geographic region; or
 - Groups of similar PCSPs likely to report the same specialty measures.
- Drafting written agreements to establish virtual groups and share accountability and financial risk;
- Developing skills and tools for group reporting that will be new to virtual groups;
- Developing skills and expertise in analyzing data and addressing any quality gaps in order to improve MIPS scores and succeed as virtual groups; and
- Developing further skills and expertise to maximize use of CEHRT, base pay on performance and take two-sided risk in order to become APMs.

Many such groups will likely need help analyzing their performance data to identify and act on opportunities for improvement within the group. A growing number of independent entities are now offering such assistance. However, clinicians seeking to form virtual groups need guidance to assess whether independent entities have the ability to help develop necessary APM capabilities in analytics, effective CEHRT use and the ability to share and manage financial risk.

Third-party certification could help emerging virtual groups identify whether such independent entities have the skills, tools and expertise needed to support transformation into the delivery system of the future. We would be very interested in exploring with you and other stakeholders whether and how to provide a third-party certification for entities offering to help clinicians develop into APMs and whether this could be incorporated into final regulations or guidance for virtual groups.

To further incentivize aggregation into virtual groups, you might consider providing MIPS bonus points for clinicians who register as virtual groups, as you propose for electronic reporting and other high-priority activities. You might also consider establishing a learning collaborative in which virtual groups could share insights, lessons learned and best practices, as well as using entities like the Office of the National Coordinator for Health Information Technology's Regional Extension Centers to provide hands-on assistance.

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: Measures in/under development for Healthcare Effectiveness Data and Information Set (HEDIS)

Domain	Measure	Status	Data Source	Denominator	Numerator
Screening	Depression screening and follow up	Under development	Electronic Clinical Data Source (ECDS)	Members 12 years of age and older.	Members who were screened for clinical depression using a standardized tool and received appropriate follow-up care if screened positive.
	Alcohol screening and brief intervention	Under development	ECDS	Members 18 years of age and older.	Members who had a systematic screening for unhealthy alcohol use and received brief intervention if screened positive.
Symptom Monitoring	Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults	In HEDIS		Members 12 years of age and older with a diagnosis of major depression or dysthymia.	Members who had a PHQ-9 tool administered at least once during a four-month period.
Medication adherence	Adherence to antipsychotic medications for individuals with schizophrenia	In HEDIS	Claims	Members 19–64 years of age with schizophrenia.	Members who achieved a PDC of at least 80% for their antipsychotic medications.
	Antidepressant medication management	In HEDIS	Claims	Members 18 years of age and older who were treated with antidepressant medication and had a diagnosis of major depression.	<ul style="list-style-type: none"> Initiation Phase. Members who had at least 84 days of continuous treatment with antidepressant medication beginning on the index prescription start date (IPSD) through 114 days after the IPSD. Continuation Phase. Members who had at least 180 days of continuous treatment with antidepressant medication beginning on the IPSD through 231 days after the IPSD.

Medication management	Follow-up care for children prescribed ADHD medication	In HEDIS	Claims	Children 6–12 years of age who were newly prescribed ADHD medication.	<ul style="list-style-type: none"> • Initiation Phase. Members who had an outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority within 30 days after the IPSD. • Continuation and Maintenance Phase. Members with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days after the Initiation Phase ended.
Access to care	Initiation and engagement of alcohol and other drug dependence (AOD) treatment	In HEDIS	Claims	Members 13 years of age and older with a new episode of AOD during the first 10 and ½ months of the measurement year.	<ul style="list-style-type: none"> • Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.
Coordination	Follow-up after hospitalization for mental illness	In HEDIS	Claims	Members 6 years of age and older who were hospitalized for treatment of mental illness.	<ul style="list-style-type: none"> • 30-day Follow-up. Discharges for which the member received follow-up within 30 days of discharge.

					<ul style="list-style-type: none"> 7-day Follow-up. Discharges for which the member received follow-up within 7 days of discharge.
	Follow-up after emergency department (ED) visit for mental illness	In HEDIS	Claims	Members who had an ED visits with a primary mental health diagnosis.	Members who received an outpatient or partial hospitalization visit with a primary diagnosis of mental health.
	Follow-up after ED visit for AOD	In HEDIS	Claims	Members who had an ED visits with a primary AOD diagnosis.	Members who received an outpatient or partial hospitalization visit with a primary diagnosis of AOD.
"Integration" of medical needs	Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications	In HEDIS	Claims	Members 18-64 years of age with schizophrenia or bipolar disorder and dispensed an antipsychotic medication.	Members who had a glucose test or HbA1c test during the measurement year.
	Diabetes monitoring for people with diabetes and schizophrenia	In HEDIS	Claims	Members 18-64 years of age with schizophrenia and diabetes.	Members who had an HbA1c test and an LDL-C during the measurement year.
	Cardiovascular monitoring for people with cardiovascular disease and schizophrenia	In HEDIS	Claims	Members 18-64 years of age with schizophrenia and cardiovascular disease.	Members who had an LDL-C test performed during the measurement year.
	Metabolic monitoring for children and adolescent on antipsychotics	In HEDIS	Claims	Members 1-17 years of age who had two or more antipsychotic prescriptions.	<p>Members who had both of the following during the measurement year.</p> <ul style="list-style-type: none"> At least 1 blood glucose/HbA1c test. At least 1 LDL-C or cholesterol test.

Overuse/ Appropriateness	Use of multiple concurrent antipsychotics in children and adolescents	In HEDIS	Claims	Children and adolescents 1–17 years of age who were dispensed an antipsychotic medication.	Members who were on two or more concurrent antipsychotic medications for at least 90 consecutive days during the measurement year.
	Opioid overuse	Under Development	Claims	Members 18 years of age and older receiving prescription opioids for > 15 days during the measurement year.	<ul style="list-style-type: none"> • High Dosage. Members who received a daily dosage of opioids greater than 120 mg morphine equivalent dose (MED) for 90 consecutive days or longer. • Multiple Prescribers and Multiple Pharmacies. Members who received prescriptions for opioids from four (4) or more prescribers AND four (4) or more pharmacies. • Multi-Provider, High Dosage: Members who had prescriptions for opioids greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer, AND who received opioid prescriptions from four (4) or more prescribers AND four (4) or more pharmacies.
Utilization	Identification of alcohol and other drug services	In HEDIS	Claims	All members	<p>Members who received the following chemical dependency services during the measurement year:</p> <ul style="list-style-type: none"> • Any service. • Inpatient. • Intensive outpatient or partial hospitalization. • Outpatient or ED.

	Mental health utilization	In HEDIS	Claims	All members	Members who received the following mental health services during the measurement year: <ul style="list-style-type: none"> • Any service. • Inpatient. • Intensive outpatient or partial hospitalization. • Outpatient or ED.
	Use of first-line psychosocial care for children and adolescent on antipsychotics	In HEDIS	Claims	Children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication.	Members who had documentation of psychosocial care in the 121-day period from 90 days prior to the IPSD through 30 days after the IPSD.
Outcomes	Depression remission/response	Under development	ECDS	Member 12 years of age and older with a diagnosis of major depression or dysthymia and an elevated PHQ-9 score.	Members who had evidence of response or remission within 5–7 months of the elevated PHQ-9 score.

Additional NCQA measures address “integrated care” for behavioral health conditions (not in HEDIS)

Measure	Data Source	Denominator	Numerator
Alcohol Screening and Follow-up for People with Serious Mental Illness (SMI)	Claims	Members 18 years of age and older with at least one inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year.	Members who were screened for unhealthy alcohol use and received two events of counseling if identified as an unhealthy alcohol user.

Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol and Other Drug Dependence	Claims	<ul style="list-style-type: none"> • SMI: Members 18 years of age and older with at least one inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year. • AOD: All members 18 years of age or older as of December 31 of the measurement year with any diagnosis of alcohol or other drug dependence during the measurement year. 	<ul style="list-style-type: none"> • SMI: Members who were screened for tobacco use and received follow-up care if identified as a current tobacco user. • AOD: Members who were screened for tobacco use and received follow-up care if identified as a current tobacco user.
Body Mass Index Screening and Follow-up for People with Serious Mental Illness	Claims	Members 18 years of age and older with at least one inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year.	Members who had calculated body mass index documented and were provided two events of follow-up care if body mass index was greater than or equal to 30 kg/m ² . Follow-up includes: <ul style="list-style-type: none"> • Two events of counseling, on different dates, for weight management (such as nutrition or exercise counseling) or • One event of counseling and one fill of medication (Orlistat) for weight management.
Controlling High Blood Pressure for People with Serious Mental Illness	Claims	Members 18-85 years of age with at least one acute inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year AND a diagnosis of hypertension.	Members whose most recent blood pressure (BP) was adequately controlled (after the diagnosis of hypertension) based on the following criteria: <ul style="list-style-type: none"> • Members 18-59 years of age whose BP was <140/90 mm Hg. • Members 60-85 years of age and flagged with a diagnosis of diabetes whose BP was <140/90 mm Hg. • Members 60-85 years of age and flagged as not having a diagnosis of diabetes whose BP was <150/90 mm Hg.
Comprehensive Diabetes Care for People with Serious	Claims	Members 18-75 years of age with at least one acute inpatient visit or two outpatient visits	Members who had an HbA1c test performed.

Mental Illness: Hemoglobin A1c (HbA1c) Testing		for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year AND diabetes (type 1 and type 2).	
Comprehensive Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Claims	Members 18-75 years of age with at least one acute inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year AND diabetes (type 1 and type 2).	Members whose most recent HbA1c level was greater than 9.0% or was missing a result, or for whom an HbA1c test was not done.
Comprehensive Diabetes Care for People with Serious Mental Illness: Medical Attention to Nephropathy	Claims	Members 18-75 years of age with at least one acute inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year AND diabetes (type 1 and type 2).	Members who received a nephropathy screening test or had evidence of nephropathy.
Comprehensive Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)	Claims	Members 18-75 years of age with at least one acute inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year AND diabetes (type 1 and type 2).	Members whose most recent blood pressure screening result was <140/90mm Hg.
Comprehensive Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%)	Claims	Members 18-75 years of age with at least one acute inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year AND diabetes (type 1 and type 2).	Members whose most recent HbA1c level was less than 8.0%.
Comprehensive Diabetes Care for People with Serious Mental Illness: Eye Exam	Claims	Members 18-75 with at least 1 acute inpatient visit or 2 outpatient visits for schizophrenia or bipolar disorder, or at least 1 inpatient visit for major depression during the measurement year AND diabetes (type 1 and type 2).	Members who received an eye exam.