



December 19, 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-FC

Dear Acting Administrator Slavitt:

The National Committee for Quality Assurance (NCQA) first thanks you for the opportunity to comment on the final rule for implementing the Medicare Access & CHIP Reauthorization Act (MACRA). We applaud the Centers for Medicare and Medicaid Services (CMS) for supporting this transition to paying clinicians for the value, rather than the volume, of care they provide.

We believe the highest priority for implementation should be to help clinicians advance from traditional practice to accountable, team-based, and patient-centered models of care. CMS must provide a clear pathway for clinicians to move along the continuum from unorganized delivery to Patient-Centered Medical Homes (PCMHs) and Patient-Centered Specialty Practices (PCSPs), virtual groups and ultimately to Alternative Payment Models (APMs). NCQA is committed to working with you and other stakeholders to support clinicians throughout this essential transformation.

We agree that flexibility in the initial transition year is critical to protecting the viability of practices – particularly those that are small and/or in rural settings. We have concerns, however, that the progress achieved through passage of MACRA could be undermined by continuing to delay full implementation of the law. We urge CMS to maintain the proposed timeline and reach full implementation of the Quality Payment Program (QPP) no later than 2019.

Finally, NCQA anticipates that we will be able to provide CMS a single data feed from our recognized PCMH practices that encompasses all reporting required under MIPS. Our redesigned PCMH recognition program, discussed in detail below, already supports reporting in the Quality and Improvement Activities categories. With approval from CMS, we can develop the appropriate module to collect and report data on Advancing Care Information as well. A unified reporting mechanism such as this would significantly reduce the burden on both CMS and clinicians. We are eager to explore this opportunity with you.

We detail these and other important priorities below. In particular, we believe CMS should:

- Move beyond simple and meaningless attestation for PCMH or PCSP to require independent, verifiable recognition for automatic Improvement Activities credit.
- Establish significantly more rigorous criteria for quality measures tied to payment under the Merit-Based Incentive Payment System (MIPS).

- Develop a framework for Virtual Groups to prepare clinicians for joint accountability and participation in Advanced APMs.
- Stratify practices by size for MIPS reporting and comparison purposes.
- Evolve Advancing Care Information measures to accelerate progress on patient engagement, care coordination, and interoperability objectives.

Stringency of Reporting Requirements & Criteria

Moving forward, it is critical that CMS require validation of PCMH or PCSP recognition by an independent third party in order to verify practice transformation. Mere attestation does not provide any meaningful assurance that clinicians and their teams deliver and sustain the essential attributes of successful PCMH and PCSP practices. Accepting simple attestation also is unfair to practices that have made investments and undertaken hard work to achieve meaningful transformation to patient-centeredness in rigorous, independent PCMH and PCSP programs.

We also note the inclusion of both state and private PCMH recognition programs through which clinicians can be awarded IA auto-credit. We are concerned that future programs proposed for auto-credit may not have rigorous standards or have sufficient data that demonstrate the effectiveness of that program on quality, cost and patient experience. Thus, not only should transparency of recognition standards be key, but any program for which CMS assigns Improvement Activity credit should be able to demonstrate – beyond the threshold number of practices stipulated in the final rule – that the program is associated with the outcomes desired to support the Triple Aim. It is only through transparency and third-party validation that CMS can assure PCMHs and PCSPs are actually organizing and delivering care in a way that’s most effective and meaningful for people and their families.

Independent, peer-reviewed studies demonstrate that the NCQA PCMH model works. NCQA tracks the evidence pertaining to the PCMH model from peer-reviewed journals and other appropriate sources and catalogues these reports in [a living document that demonstrates the profound success of the model](#). To achieve the same or better level of influence through MACRA, CMS should not accept programs less rigorous than that which has been associated with PCMH success.

Regarding the criteria for Medical Home Models qualifying as Advanced APMs, we strongly urge CMS to require that models meet all seven of the domains listed in the final rule’s definition of a Medical Home Model:

- (1) Planned coordination of chronic and preventive care;
- (2) Patient access and continuity of care;
- (3) Risk-stratified care management;
- (4) Coordination of care across the medical neighborhood;
- (5) Patient and caregiver engagement;
- (6) Shared decision making; and
- (7) Payment arrangements in addition to, or substituting for, fee-for-service.

All seven domains are key elements of a true medical home.

We are also very concerned that CMS finalized inadequate criteria for quality measures under MIPS. At present, the criteria set a low bar by only requiring “evidence-based, valid and reliable.”

These are not sufficiently stringent, do not advance MACRA's goals for improving quality, and create potential for gaming. Measures must also be clinically important, transparent, feasible, actionable and rigorously audited to ensure accuracy and fairness. NCQA has developed quality measures through broad, multi-stakeholder engagement and consensus for over 25 years. It is this experience and expertise that informs the criteria listed above.

There is no point to measures that are not clinically relevant to clinicians and their patients/families, or the health care system overall. There is great potential for gaming if measures are not publicly transparent about 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 by clinicians and their teams. And rigorous auditing is essential to ensuring real quality improvement and honest reporting.

We support implementing the proposed (although not finalized) requirement that clinicians be required to report at least one cross-cutting measure. While challenging to identify and implement cross-cutting measures suitable for different specialties and primary practice, there are some clearly defined clinical areas where clinicians would likely agree that they have a role to play:

- Controlling High Blood Pressure
- Medication Reconciliation (following inpatient discharge)
- BMI Screening and Follow-Up
- Tobacco Use Cessation Counseling and Treatment
- Advance Care Planning

Each of these has measures readily available and reflect national priorities and public health importance. More importantly, these are areas that patients can expect their clinician to take action.

We also believe that CMS should require a designated seat for consumer representation on the Physician Focused Payment Model Technical Advisory Committee (PTAC). There is currently no voice for consumers or consumer advocates on the PTAC. CMS relies on this committee for review of APMs and the MACRA legislation requires that APMs meet Patient Choice and Patient Safety criteria. A consumer representative will be critical to verifying that proposed models meet the statutory requirements of patient-centeredness.

Virtual Groups & Promoting Joint Accountability

One of the primary objectives of MACRA is to encourage clinicians to aggregate, share financial risk and work together in groups. These efforts promote joint accountability and will create delivery systems that are better able to improve the cost, quality and experience of care. However, clinicians need detailed guidance from Medicare on how to proceed, including specific pathways to participation in Advanced APMs. As noted in [their letter to you](#), Representatives Price and Roe emphasized Virtual Groups' role in helping clinicians (particularly in small practices) to participate in sophisticated delivery models.

CMS should immediately begin to develop tools, resources, technical assistance, and other materials for guidance as to how clinicians can form these groups. Many individual clinicians may already be prepared to take this initial step but are also at risk for penalties given that CMS projects a majority of small practices will suffer negative adjustments under MIPS.

CMS should offer those clinicians more and greater opportunities to participate in organized systems and avoid those negative adjustments. Providing bonus points for Virtual Group participation could provide another lever to drive this migration.

Practices with NCQA PCMH and PCSP recognition make ideal Virtual Group partners. These clinicians have demonstrated commitments to well-coordinated, high-quality patient-centered care and thus greater potential to improve MIPS scores. Recognized practices within the same geography or PCSPs that are likely to report the same specialty measures are both well-positioned to develop into Virtual Groups. NCQA would very much appreciate the opportunity to help CMS think through how we can best support these types of practices that wish to report as a group.

NCQA is also eager to work directly with CMS to develop a framework for establishing minimum standards for Virtual Groups. The standards for the NCQA PCMH program provide a solid foundation for this type of framework. NCQA's program meets CMS goals by focusing on promoting and enhancing care coordination and patient engagement, improving quality and outcomes, increasing access and continuity of care, and effectively using data for meaningful analytics.

In April 2017, NCQA will launch a redesigned PCMH program that includes new standards, new scoring, an annual recognition requirement (as opposed to a 3-year cycle), and the option for practices to submit electronic clinical quality measures (eCQMs) to NCQA for credit towards recognition. NCQA will be establishing connections with EHR companies, qualified clinical data registries, health information exchanges, and analytics companies so that practices can report eCQMs through these entities. This is part of our effort to shift our evaluation programs to incorporate more performance elements while we streamline and refine the structure/process components. The list of eCQMs from which practices can choose to report aligns with CMS expectations in CPC+, MIPS, and the CMS/AHIP Core Collaborative measures. We plan to introduce similar changes for the PCSP program in 2018. NCQA would welcome the opportunity to share more details about these important and meaningful updates.

We also believe that NCQA can support all MIPS reporting requirements for NCQA-recognized practices with CMS approval of an additional module we can develop to collect Advancing Care Information (ACI) requirements. We could leverage the redesigned PCMH program, as well as the eCQM reporting process described above, to seamlessly collect, validate and report all the necessary data to complete the MIPS reporting requirements on behalf of our PCMHs (and PCSPs starting in 2018). This would reduce administrative burden and redundancy for both clinicians and CMS. We feel this could also provide an excellent platform for piloting the Virtual Group program.

Additional direction beyond what is outlined above will be needed for successful implementation of Virtual Groups. We suggest CMS offer, at minimum, detailed guidance on:

- 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 participate in APMs.

Flexibility & Transition Period

It is critical that CMS reach full implementation of the QPP by no later than 2019. The goal of MACRA is to encourage clinicians, through robust incentives and heavy penalties, to participate in more sophisticated delivery models. CMS must leverage both the full incentives and penalties, or risk undermining the entire premise of the QPP.

Full implementation includes moving beyond Pick Your Pace and requiring completion of full year reporting requirements (or participation in an Advanced APM) in order to avoid penalties.

CMS must also require validation of PCMH or PCSP recognition by an independent third party in order to verify practice transformation. Mere attestation does not provide any meaningful assurance that practices deliver the essential PCMH and PCSP services.

It may also be helpful to consider offering partial Improvement Activities credit for those practices that are in the process of transformation but have not achieved recognition by October 1 of a given performance year.

CMS indicated that, at least during the Pick Your Pace transition year, only one practice within a Tax Identification Number (TIN) need be recognized as a PCMH for the entire TIN to receive auto-credit for Improvement Activities. NCQA strongly discourages continuing this policy past the transition year. NCQA can provide a direct list of all recognized practices and clinicians, through which CMS can verify that practices are recognized. It is absolutely critical that only those clinicians that have truly transformed their practice receive credit.

CMS may still wish to offer additional flexibility. As previously discussed, stratifying benchmarks by practice size would allow for more fair and equitable comparisons across clinicians and the contexts in which they practice. We understand the reticence to do so but such a methodology would help prevent burdensome penalties on small and rural practices that have more limited resources to substantially improve quality in the immediate term. Alternatively, CMS could adjust MIPS payment adjustments for practice size to account for that disparity. CMS could incentivize those same clinicians to aggregate into group reporting by implementing a robust Virtual Group platform and tying bonus points to participation in those groups.

Health IT & e-Measurement

NCQA strongly recommends that CMS focus on working toward more and better outcome measurement and measures derived from data entered into electronic systems as a natural part of clinical workflow. This includes data solicited directly from the patient, as measurement today is largely based on claims that lack data on outcomes. Rich patient-generated data directly contributes to broader development and use of Patient-Reported Outcomes Measures (PROMs). It also facilitates more shared-decision making and care planning. 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.

We are particularly encouraged to see that CMS will offer bonus points for electronic reporting as incentives will drive the movement toward measurement based on data derived as a part of, not in addition to, normal clinical workflows.

This transition will also alleviate some of the burden associated with measure reporting. Using large electronic clinical data systems and innovative outcome measures will increase the accuracy, efficiency and timeliness of information needed to customize and improve care for individual patients. We are, however, concerned about the accuracy of electronic clinical quality measurement reporting from health IT systems. 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 in order to ensure that payments tied to quality measures are based on accurate, reliable, and verifiable data. NCQA would welcome the opportunity to demonstrate how we address these issues through our eMeasure Certification program.

We continue to believe that more stringent measures of health IT use are necessary to move towards the substantial, person-centered use of health IT that supports health system transformation. We believe that CMS should signal now the timing and strategies for increasing the stringency of the ACI performance category measures.

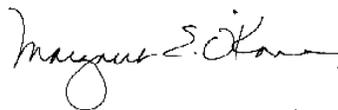
We recognize that some clinicians need more time to incorporate patient-facing ACI measures into their workflows, but believe it is important to set expectations for future required use of EHRs.

We encourage CMS to consider increasing the weight of the performance score relative to the base score, establishing thresholds for performance measures, and adding additional patient-facing measures to the base score.

The definition of Meaningful EHR User will also have an important effect on robust health IT adoption and use. We are pleased that CMS finalized its proposal to use a 75-point threshold (rather than the alternate proposal of 50 points) to determine Meaningful EHR Users.

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,

A handwritten signature in black ink, appearing to read "Margaret O'Kane". The signature is fluid and cursive, with a large initial 'M' and 'O'.

Margaret O'Kane,
President