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Administrator Verma:

The National Committee for Quality Assurance (NCQA) thanks you for the opportunity to comment on the Request for Information: Innovation Center New Direction. We applaud the Administration for recognizing that the Innovation Center is a powerful tool for driving the transition from volume to value-based care.

We support cost and quality transparency as a tool for market-driven reform. However, truly patient-centered care avoids merely shifting additional costs to beneficiaries, as high costs create barriers to needed care and ultimately result in worse patient outcomes. We recommend a series of concrete actions to engage beneficiaries in model design, such as establishing Innovation Center patient advisory councils. Doing so will foster models that leverage consumer accountability without impeding beneficiaries from seeking high-value care.

We also urge you to explore electronic measurement as a legitimate avenue for reducing reporting burden on clinicians. Using electronic data will increase the scope, accuracy, efficiency and timeliness of information needed to both design models with meaningful outcome measures as well as customize care for individual patients. We therefore strongly support greater use of eMeasures in model design.

For guidance on state-based delivery reform, we urge you to look to and align with existing efforts. NCQA Patient-Centered Medical Home (PCMH) continues to be a prominent design feature among states' transformation efforts; the model is often built into financial incentive structures and used as a standardized measure of practices' capability to provide advanced primary care. Alignment of clinical transformation expectations as well as payer incentives and resources will more likely generate cost savings for both the state and the federal government.

Finally, we emphasize that behavioral health models offer myriad opportunities for performance measures based on patient-reported outcome measure (PROM) development. PROMs are a powerful tool for generating truly consumer-directed care, as they allow patients themselves to observe and help define the value of their health care outcomes. NCQA is leading cutting-edge work in this area and with CMS support could focus on even more performance measures capturing patient preferences and perspectives.

We propose the following considerations for shaping CMMI policy and model development:

- Explore and facilitate existing outside models, including those in which traditional Medicare is not a participant. We urge you to consider successful models from Medicare Advantage (MA), Medicaid and commercial payers for Innovation Center sponsorship, support, and demonstration.
- “Patient-centered” means establishing open, collaborative relationships with patients to engage them in their own health and health care. Cost and quality transparency are powerful tools to enhance their engagement. However, merely shifting costs to patients is not “patient-centered” as it creates barriers to needed care, produces worse outcomes and impedes the high-value health care system we all seek to achieve.
- To truly be patient-centered, flexible benefit designs can be structured to share savings from more efficient, higher quality care with patients. This can help to incentivize them to seek out high-value providers and treatments. Such models can be structured so that flexibility enhances access – but does not create unintended barriers – to high-value care such as NCQA PCMHs and evidence-based treatments for chronic conditions.
- Emphasize the transition to electronic measurement. Although many challenges remain, this transition will alleviate some of the burden associated with measure reporting by leveraging data derived as a part of, not in addition to, normal clinical workflows. Using electronic data will also increase the scope, accuracy, efficiency and timeliness of information needed to both design models with meaningful outcome measures as well as customize care for individual patients.

We offer additional feedback on specific model areas below.

Expanded Opportunities for Participation in Advanced Alternative Payment Models (AAPMs)

It is essential that the Innovation Center focus primarily on broadening opportunities for AAPM participation. Expanding participation must come by widening opportunities to participate in an AAPM and making that participation more attractive, rather than by weakening existing standards for what constitutes an AAPM.

For example, CMMI can expand voluntary episodic payment models for nationwide participation. You can give clinicians who are ready for more sophisticated payment mechanisms the opportunity to participate on a voluntary basis. You can evolve existing models with FFS tracks to have more population-based payment tracks. For example, we strongly support building upon and increasing the attractiveness of the sophisticated payment mechanisms in programs such as Next Generation ACO and Comprehensive Primary Care Plus (CPC+). We also support giving MACRA-eligible clinicians credit for participation in Medicare Advantage APMs.

We urge you to consider how CMS can leverage existing private sector efforts to both broaden participation in AAPMs and reduce reliance on federal oversight. For example, given the complete overlap between NCQA PCMH and the Comprehensive Primary Care Functions in CPC+, CMS could consider using our private sector program to manage the CPC+ initiative rather than continue to spend time and effort managing the program. This would not only save federal dollars and workforce hours, it would lower the burden on practices who are involved in both programs. It could also be a pathway for CMS to expand the CPC+ program – an existing AAPM opportunity – to all 50 states by giving credit to all NCQA-recognized PCMHs.

Finally, CMMI can provide a standard set or sets of compliance and benefit waivers for AAPMs, such as for the use of telemedicine and Stark law exemptions. A standardized approach to this would facilitate more efficient development and review of model proposals. We would be happy to work together to identify a set of waivers that would ease the regulatory burden on clinicians without negatively impacting the quality of care provided. We also encourage you to consider testing new documentation methods to reduce the burden of the current Evaluation & Management code requirements.

Consumer-Directed Care & Market-Based Innovation Models

NCQA strongly supports the use of tools that inform consumers about the cost and quality of their care options. However, it is of paramount importance that you evaluate the potential negative effect on quality of care and value when considering models that shift more cost accountability to patients.

We support broadening value-based insurance design (VBID) in MA as well as other managed care programs, both public and private. We can help CMMI identify high-value practices, plans and services in several ways because the NCQA stamp of approval is an objective and meaningful way of informing patients and other stakeholders about value.

Given the rigorous standards in NCQA's PCMH & Patient-Centered Specialty Practice (PCSP) programs, clinicians in practices that achieve NCQA recognition have demonstrated high value through their commitment to improving quality and patient experience while controlling costs. Savings from these more efficient, high-quality practices can be shared directly with patients and coupled with education on the benefits of patient-centered care. This could encourage patients to seek out, and even demand broader access to these high-value clinicians.

The patient engagement standards in these programs can also function as the foundation for consumer-directed care models. We require that our recognized clinicians empower patients and caregivers not only with robust information about quality and access, but also about self-management and the cost implications of treatment options. These standards can provide a framework for an effective model that increases consumer accountability.

Physician Specialty Models

Because most specialists currently lack meaningful APM opportunities, we urge you to focus on broadening these opportunities. Most existing models are episodic or bundled, so we encourage you to focus on increasing population-based and prospective payment specialty APMs. These are particularly important for specialists participating in clinical transformation or delivery reform initiatives, manage chronic conditions and/or function as a primary care provider for an episode of care (such as oncologists and OBGYNs).

NCQA's PCSP program and Oncology Medical Home are ideal clinical frameworks for specialty APMs. PCSP already provides Improvement Activity credit in MIPS and we believe there is ample opportunity to evolve this to a sophisticated APM. Coupling this recognition program with meaningful specialty-specific outcome measures and a prospective payment methodology would provide the foundation for the first true specialty medical home APM.

Oncology Medical Home has significant overlap with the existing Oncology Care Model, but we believe there may be opportunity for further alignment that benefits participating clinicians. Prospective payment is of particular importance to these clinicians as they committed to transforming practice infrastructure and care management – activities that initially incur costs but produce powerful patient benefits once implemented. We are eager to work with you to explore these opportunities.

Finally, voluntary participation in bundled payment models could result in limited variation in measure performance across participants because only those clinicians who can succeed in the bundle will participate. Careful selection of measures is necessary to address variation and produce a meaningful effect. We are therefore particularly interested in helping CMS understand how quality measurement needs should differ between mandatory and voluntary bundles.

MA Innovation Models

As mentioned above, we strongly support expanding VBID in MA across the country. NCQA can support CMMI as you explore opportunities for VBID expansion, including identification of high-value practices, plans, and services. Beginning in April 2018, our new PCMH platform will leverage practice-level electronic clinical quality measures (eCQMs) which facilitate a granular analysis of high-value practices. We also support granting MACRA-eligible clinicians credit for participation in MA APMs.

State-Based and Local Innovation Models

NCQA collaborates on delivery system reform with leadership in several states. We believe these arrangements deserve priority consideration as model frameworks for use in other states. The structure, approach, and design of these arrangements vary based on local and regional priorities.

Although many state initiatives are underway, relatively few have been evaluated for impact on total cost of care or health outcomes, likely since many are relatively new and there has not been sufficient time to evaluate long-term results. However, it is evident that many states are leveraging federal funding to support transformation efforts, such as CMMI State Innovation Model (SIM) grants and Medicaid Delivery System Reform Incentive Payment (DSRIP) program. The NCQA PCMH model continues to be a prominent design feature among states' transformation efforts and is often built into financial incentive structures.

For example, we collaborated with the Tennessee Health Care Innovation Initiative, which is supported through the SIM grant award, to implement PCMH statewide. TennCare (Medicaid) leverages the NCQA model, expands on the existing PCMH efforts in the state, and requires recognition for providers to be eligible for incentive payments. The program employs multiple payment mechanisms to facilitate the transition from volume to value-based care: enhanced FFS, risk-adjusted care management fees, as well as outcomes-based payments. The program leverages an even more sophisticated payment mechanism for practices with large patient panels – an approach we strongly support.

For high-volume PCMH organizations with 5,000 or more members, savings on total cost of care (TCOC) generated through the PCMH program will be shared based on each organization's actual risk-adjusted TCOC relative to its benchmark. For low-volume practices (fewer than 5,000 members), organizations may earn payments for annual improvement on efficiency metrics. While the TennCare PCMH Program is intended for providers serving the state's Medicaid population, providers participating in the CPC+ program remain eligible to participate. Alignment of payer incentives and resources, as evident in the Tennessee model, will more likely generate cost avoidance and cost savings for the state.

The New York DSRIP program also includes expectations for practices to achieve and retain medical home recognition. NCQA PCMH is prominently used in this model as well.

Performing Provider Systems (PPSs) are incentivized to meet specific metrics and milestones (including recognition), report a standardized measure set, and attain specific outcome targets. To ensure the long-term sustainability of DSRIP investments, the state intends to make 80-90% of total MCO payments using value-based payment methodologies by the end of DSRIP Year 5. The state maintains a Value-Based Payment Roadmap, which outlines various levels of increased risk consistent with the Health Care Payment and Learning and Action Network Alternative Payment Model Framework. The state is leveraging the DSRIP/VBP efforts in Medicaid and intends to subsequently ensure that Medicare's reform efforts align with the Medicaid initiative.

As you mentioned in the RFI, multi-payer models offer promising opportunities for increasing wide-scale participation in reform. However, securing multi-payer participation is contingent upon incorporating existing efforts.

For example, because of Star Ratings, Medicare Advantage plans have long-standing incentive structures and risk agreements in place that drive substantial portions of their revenues. Many Medicaid programs have also invested heavily in bundled or global payment initiatives. Any national model or alignment effort would need to acknowledge these as well as commercial payer models for those plans and clinicians that participate in both public and private programs. This would mitigate the risk of conflicting payment models that generate cross-purpose incentives and would also ensure that participating MCOs remain financially viable.

Similarly, models must be flexible enough to ensure that model participants can meet the needs of their specific populations. For example, commercial insurers within Tennessee's public employee benefits program were unable to participate in the state's SIM initiative because that particular model was so heavily focused on Medicaid. Addressing these challenges and others will be critical to the success of state-based, multi-payer delivery system reforms.

To get an accurate evaluation of readiness and continued transformation toward patient-centered care, we recommend using a consistent practice assessment tool. Standardized models such as NCQA PCMH and PCSP could provide the desired consistency. For example, the State of Vermont Blueprint for Health used NCQA PCMH as a multi-payer standardized measure of practices' capability to provide advanced primary care. This provided the necessary foundation for practices to participate more broadly in reform efforts through SIM testing.

Managed Long-Term Services and Supports (MLTSS) is another priority area for many states. We strongly encourage you to further explore models that support moving beneficiaries with LTSS needs into managed care. NCQA developed a set of standards for plans and community-based organizations delivering MLTSS and these could be used for such models.

Our program addresses the unique needs of individuals receiving LTSS in the home and community, including the non-medical supports necessary to provide well-coordinated, comprehensive care. Leveraging this accreditation for programs such as the Financial Alignment Demonstrations could offer the alignment and standardization that is critical to model success.

Finally, we recommend transitioning to mandatory reporting of the Medicaid Core Set for all states, including states with only traditional FFS Medicaid. This is an essential first step toward increasing participation in value-based care and curbing the growing costs of Medicaid programs across the country. As you consider changes to Medicaid funding more broadly, we urge you to consider quality measurement as a tool for improving on overuse and overspending for high-cost services such as imaging for low back pain.

Mental and Behavioral Health Models

NCQA has long believed that we must prioritize additional measure development for mental and behavioral health. We have significant expertise and have been heavily focused on this in recent years. For example, in 2016, NCQA adapted a suite of existing provider level quality measures of depression care.

These measures capture the quality of care at key points along the continuum of depression management and treatment. The suite effectively measures screening for depression as well as the use of a standardized tool to monitor symptoms, follow-up, and the associated patient-reported outcome (remission or response to treatment).

Initially developed and collected by Minnesota Community Measurement, health plans now collect these measures nationwide for HEDIS® reporting. They are specified to leverage electronic data from multiple sources – electronic health records, health information exchanges, registries, and even claims – to assess the full spectrum of depression care. Leveraging data from electronic clinical data systems is critical to minimizing the administrative burden involved in measurement.

NCQA sees these measures as an opportunity to revolutionize the way quality data are collected and reported. We are eager to work with you to replicate this comprehensive approach to measurement and develop additional behavioral health measures for inclusion in relevant models.

Access to data has and will remain an immediate obstacle to any successful behavioral health model. States frequently have siloed delivery of social and medical services through separate agencies, so participants must support data sharing agreements across those siloes. Any model for integrated behavioral health care must include explicit direction about what data can and cannot be shared, who may authorize data sharing, as well as expectations for sharing data collected through social and community-based services. This is essential information that must be shared with the appropriate medical providers.

Although it may not be feasible to compel behavioral health providers to share certain data, we strongly encourage the development of models that offer incentives to do so. We recommend a “data follows the person” approach where a single passport inclusive of medical, behavioral, and social data is accessible across systems and providers. Leveraging and building upon community-based registries can provide the foundational infrastructure for such an approach.

Finally, for models oriented around behavioral health integration with primary care, we encourage you to look at PCMH PRIME in Massachusetts. NCQA adapted our PCMH program to meet the state’s priorities for comprehensive care, including behavioral health integration.

Beneficiary Engagement in CMMI Model Development and Design

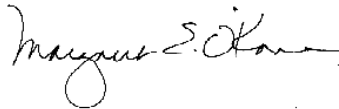
We strongly support soliciting input from the full range of stakeholders and believe it can contribute greatly to your work. Engagement of beneficiaries and their advocates is particularly important to transformation initiatives’ sustainability and impact. As you proceed, we call for mechanisms to ensure beneficiaries and their advocates are involved in the development, implementation, and evaluation of these models.

We recommend the following actions:

- Convene regular meetings of a consumer and patient advisory council;
- Create multi-stakeholder advisory panels on specific delivery and payment models;
- Involve beneficiaries and their advocates in Technical Expert Panels (TEPs);
- Solicit public feedback on proposed model designs;
- Regularly engage beneficiaries and their advocates as new models are implemented;
- Publicly release all data, metrics, outcomes, and evaluation findings for each model;
- Enhance support for beneficiaries via 1-800-MEDICARE and State Health Insurance Assistance Programs (SHIPs);
- Carry out beneficiary testing and readability reviews of patient-facing content for each model; and
- Establish an APM Ombudsman, per your proposal.

Thank you again for inviting comments on the Innovation Center's new direction. If you have any questions about the feedback and opportunities proposed, please contact Joe Castiglione, Manager of Federal Affairs, at castiglione@ncqa.org or (202) 955-1725.

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