November 12, 2013

The Honorable Max Baucus, Chairman
The Honorable Orrin Hatch, Ranking Member
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510
sgrcomments@finance.senate.gov

The Honorable David Camp, Chairman
The Honorable Sander Levin, Ranking Member
House Ways & Means Committee
1102 Longworth House Office Building
Washington, DC 20515
sgrwhitepaper@mail.house.gov

Thank you for your leadership in reforming Medicare’s physician payment system to reward value instead of volume. The National Committee for Quality Assurance (NCQA) strongly supports this transition which parallels our 23 years of work to improve both quality and value through measurement, transparency and accountability. Your committees’ SGR Repeal and Medicare Physician Payment Reform Discussion Draft makes important strides in this movement.

**Complex Chronic Care Management Services:** We especially support the provision to pay for complex chronic care management services, which will reward physicians for non-face-to-face services that improve quality and prevent costly complications. Clinicians in NCQA-recognized Patient-Centered Medical Homes (PCMH)\(^1\) and Patient-Centered Specialty Practices (PCSP)\(^2\) are ideally suited to provide this service because of their demonstrated commitment to providing patients with care coordination services that improve value. We offer three levels of recognition that demonstrate practice’s ability to provide the management that people with complex chronic conditions need and deserve.

The NCQA standards call for providers in our programs to have a proactive mechanism for identifying people who have complex chronic care needs. This is critical for ensuring that all such patients can benefit. Level 3 practices also meet high standards for enhanced access, tracking and coordinating referrals, care planning and management, population management and performance measurement and improvement. We urge you to require all providers billing for these services to meet equally rigorous standards and not allow a “least common denominator” approach that minimizes benefits for this vulnerable population.

It also is important to ensure that standards continue to evolve to further raise the bar as we learn more about how to improve the quality, cost and efficiency of patient-centered care. Legislation and regulations should not lock in current standards or inhibit further innovation. We regularly update our programs and, for example, now include strengthened requirements for complex care management, care coordination, resource stewardship and meaningful use of health IT.

---

\(^1\) [http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx](http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx)

\(^2\) [http://www.ncqa.org/Programs/Recognition/PatientCenteredSpecialtyPracticePCSP.aspx](http://www.ncqa.org/Programs/Recognition/PatientCenteredSpecialtyPracticePCSP.aspx)
We urge you to further strengthen support for PCMHs through per-member-per-month payments, as many commercial insurers and state programs do. All patients can benefit from the improved coordination, access and patient-centeredness of PCMHs. A growing body of research now documents that NCQA-recognized PCMHs improve quality and lower costs by preventing costly hospital admissions and emergency department visits.\(^3\)\(^4\)\(^5\)\(^6\)\(^7\)\(^8\)

Medicare also should continue demonstrations, such as the Multi-payer Advanced Primary Care Initiative, that offer per-member-per-month payments for all beneficiaries receiving PCMH care. Giving all patients PCMH benefits may prevent or delay the need for complex chronic care management by addressing the full continuum of care. However, it likely will take longer than a few short years to document that impact on Medicare enrollees alone. Withdrawing Medicare per-member-per-month support prematurely could discourage other payers from continued support of these multi-payer, all-patient initiatives before they have sufficient time to yield the full measure of their potential benefit. Concerns about paying twice for the same service instead could be addressed by precluding practices in the demonstrations from billing for the new complex chronic care management service codes.

**Performance Measurement:** We agree that performance measurement should address quality, resource use, clinical practice improvement and meaningful use of health IT. These are all integral parts of our PCMH and PCSP programs, and we note that we can identify for Medicare which practices in our programs meet meaningful use criteria.

There should be clear criteria for individual measures, including documentation of clinical importance, evidence base, transparency, reliability, validity, feasibility, ability to act on results and rigorous auditing. We also recommend that measures capture the most meaningful aspects of quality – including outcomes – which we value in a given specialty. This may not be possible immediately, but should be the eventual goal. We further support higher weights for outcome measures, include intermediate outcomes such as blood pressure control, as well as adverse events, and encourage patient-reported outcome measures.\(^9\)

\(^7\) Takach, M, *Reinventing Medicaid: State Innovations To Qualify And Pay For Patient-Centered Medical Homes Show Promising*, Health Affairs, July 2011. http://content.healthaffairs.org/content/30/7/1325.abstract
\(^8\) Harbrecht, M, Latts, L. *Colorado’s Patient-Centered Medical Home Pilot Met Numerous Obstacles, Yet Saw Results Such as Reduced Hospital Admissions*, Health Affairs, September, 2012. http://content.healthaffairs.org/content/31/9/2010.abstract
\(^9\) *Standards for Patient-Reported Outcome–Based Performance Measures*, Basch, Torda & Adams, JAMA, July 10, 2013
We strongly support your proposal to encourage clinical practice improvement activities and give recognized PCMHs and PCSPs the highest possible score for this. PCMHs and PCSPs have demonstrated through the recognition process their compliance with clinical practice improvement activity criteria:

- Enhanced access, including same-day appointments and after-hours access to clinician advice;
- Population management capabilities for tracking individuals to provide timely care interventions;
- Timely communication of clinical information that is needed for care coordination; and
- A commitment to beneficiary engagement, including establishment of care plans for patients with complex needs and self-management training.

We would be happy to provide detailed documentation of this from our standards.

We strongly support group level reporting and measurement via “virtual groups” for small practices or facility-based providers. This helps address concerns about measurement at the individual provider level. Concerns about measuring individuals include: adequate sample sizes for statistical significance; the need for risk adjustment sensitive to variation among small groups of patients; and concerns about incentives that discourage providers from taking difficult cases.

We further support extra help for small rural or health professional shortage area practices with quality efforts, and suggest using health IT Regional Extension Centers as another vehicle for this assistance. We also applaud your emphasis on promoting appropriate use criteria and closely examining outliers for potential over-utilization and sanctions.

**Performance-Based Rewards and Accurate Payment Rates:** It also is critically important that the amount of performance-based rewards be sufficient to counter other financial incentives, such as excess payment for currently misvalued services. We therefore strongly commend you for including:

- A substantially larger pool of funding for performance-based incentives than previous Medicare physician payment reform proposals;
- Strong provisions, including clear targets for bringing down payment rates for over-valued services that otherwise could trump pay-for-performance incentives; and
- Appropriate use criteria and reviewing outliers for over-utilization and potential sanctions.

**Alternative Payment Models:** We support Alternative Payment Models (APMs) and applaud your emphasis on multi-payer alignment. Our PCMH and PCSP programs also can be foundations for alternative payment models, although they do not proscribe specific payment approaches, they are helpful in establishing what the payment is tied to.

**Physician Compare:** Finally, we want to stress the importance of thoroughly testing how Medicare presents provider performance information to beneficiaries on the Physician Compare website. The information should be presented in ways that people with a wide range of health literacy skills find useful. We urge you to be careful that the presentation does not inadvertently steer people to clinicians who provide more services, as some people equate more utilization with higher quality.
Thank you again for your leadership in reforming Medicare physician payment to reward value instead of volume. For any questions about our comments please contact Paul Cotton, Director of Federal Affairs, at cotton@ncqa.org or (202) 955-5162.

Sincerely,

Margaret O’Kane,
President