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November 17, 2015

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue SW
Washington, D.C. 20201

Re: Response to Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models

Dear Acting Administrator Slavitt:

The Network for Regional Healthcare Improvement (NRHI) appreciates the opportunity to respond to the above-referenced Request for Information (RFI). NRHI is a national organization representing 40 Regional Health Improvement Collaboratives (RHICs). These multi-stakeholder organizations are working in their regions and collaborating across regions to transform the healthcare delivery system to achieve better care at a lower cost. The RHICs are accomplishing this transformation by working directly with physicians and other healthcare providers, provider organizations, commercial and government payers, employers, consumers and other healthcare related organizations, to achieve healthcare improvement goals in their respective regions. NRHI and its members are non-profit, non-governmental organizations.

We know that the traditional fee-for-service payment model has proven to be a barrier for achieving reform, failing to provide the right tools and incentives to improve the way care is delivered and improve health outcomes. Congress made important progress in removing this barrier through passage of the Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10) (MACRA), which reforms how physicians are paid and advances payment systems that reward the value, rather than the volume, of care. For these critical reforms to have their desired impact on nationwide health care delivery, they must be implemented in a manner that makes success widely attainable and sustainable.

CMS has a variety of levers it can use to achieve widespread and sustainable reform. It has partnered with RHICs on a variety of delivery system reform initiatives, and the partnerships that have been successful should be continued or expanded as part of the MACRA reforms. MACRA itself also creates a number of new roles, and new opportunities

for partnership with entities like RHICs that are already playing many of these roles in their communities. For instance, there will be roles for entities to work directly with physicians to assess the new payment systems and models, to convene physicians into virtual groups, to help physicians meet obligations under the MIPS or transition to new payment models, to provide feedback and education to physicians and to work with physicians on activities that improve their practice. **To the extent that these roles can be consolidated within one organization or a network of aligned organizations, implementation will be more efficient and manageable for providers and for CMS. NRHI urges CMS to seek ways to align and integrate these various roles at the local or regional level, and give providers a clear path to the various tools they need to succeed in this new value-based payment environment and improve the care they provide to patients.** It is through this lens that NRHI offers the following responses to the RFI.

The Merit-Based Incentive Payment System

Virtual Groups

Getting to the best, most meaningful data often requires a level of granularity that only individual reporting can achieve. However, we recognize the challenge policymakers face in adjusting payments based on variations in physician performance at the individual clinician level. We therefore support the concept of virtual groups for purposes of MIPS performance scoring. Virtual groups will be important in allowing Medicare to identify meaningful variations in performance, and we encourage CMS to look to RHICs as potential partners in this effort. Many RHICs have long histories of bringing groups of providers together for measurement and improvement purposes, and many could readily support virtual groups. RHICs also have access to data and analytic capabilities that make them well positioned to assist virtual groups in meaningfully participating in the MIPS and helping CMS as it pilots the virtual group option. CMS should look to leverage RHICs and their existing capabilities, rather than recreate this asset.

NRHI offers the following response to CMS' specific questions on virtual groups:

- *Should there be a limit placed on the number of virtual group elections that can be made for a particular performance period for a year as this provision is rolled out? We are considering limiting the number of voluntary virtual groups to no more than 100 for the first year this provision is implemented in order for CMS to gain experience with this new reporting configuration. Are there other criteria we should consider? Should we limit for virtual groups the mechanisms by which data can be reported under the quality performance category to specific methods such as QCDRs or utilizing the Web interface?*

NRHI agrees that CMS should limit the number of voluntary virtual groups as it gains experience with this new reporting configuration. Successful implementation of this new configuration will require trust and support from the physician community. Further, physicians will need organizational and administrative tools to understand their group's performance and the actions they need to take to improve their collective performance. For this reason, NRHI encourages CMS to consider limiting participation to physicians

and small practices that partner with neutral third parties, like RHICs, that have the experience, resources and data necessary to support the group.

Quality Performance Category

The goal of any quality-based payment system should be to pay providers for behaviors that result in better outcomes for patients and populations. Performance measurement, therefore, should be based on quality measures that are understandable to patients and payers, actionable by providers, important to stakeholders and have the proven effect of driving improvements in care delivery. In implementing the MIPS, the overarching goals should be reducing the number of measures that physicians report on and emphasizing those measures that matter most to stakeholders – in other words, focusing on measures that produce meaningful and actionable information. Too often measures that matter most to patients and purchasers are not widely adopted or used due to limitations of data, cost of implementation and resistance from stakeholders.

NRHI recognizes the challenges in streamlining and aligning a multitude of measures that vary across payers, programs and health care settings, and isolating the best, most meaningful measures. But we believe this work is critical, and that an appropriate amount of the funding MACRA provides for measure development should be directed toward testing measures in the field. Piloting priority measure implementation will increase understanding of scalability, identify solutions and build the business case for broader measure use. A small number of high-priority measures should be identified, including Total Cost of Care and Patient Reported Outcomes, for targeted implementation across regions to prepare for national scale and use. Ideally, we believe these measures would be tested through multi-stakeholder organizations like RHICs, who have extensive experience working within their communities to test measures and identify measures that are trusted and meaningful to providers, payers, employers and consumers. NRHI looks forward to being part of this effort and intends to seek opportunities to engage with the federal government as it undertakes development and implementation of the Measure Development Plan called for in Section 102 of MACRA.

NRHI offers the following response to CMS' specific questions on the quality performance category:

- *Should we maintain all PQRS reporting mechanisms under MIPS?*

NRHI encourages CMS to place more emphasis on reporting through Qualified Clinical Data Registries (QCDRs). QCDRs allow for more robust uses of clinical data, and can incorporate clinical data from non-Medicare patients, creating a more complete picture of a practice. We also see opportunities for alignment between QCDRs and Qualified Entities or other RHICs with access to multi-payer claims data, as a means to combine clinical and quality data.

CMS should also consider emphasizing solutions that meet multiple federal data reporting requirements. One way to do this is to allow third parties like Health

Information Exchanges (HIEs) and others to collect, aggregate and submit data according to clear and aligned parameters to meet the requirements of ONC, CMS and other entities. This would greatly simplify reporting for healthcare providers, and has a precedent in the QCDR program. Many HIEs, including some that are NRHI members, have deep resources of clinical data and are currently using it to report quality data, like HEDIS measurement, to other payers.

- *Should we maintain the policy that measures cover a specified number of National Quality Strategy domains?*

NRHI agrees that providers should be reporting on a balanced set of measures. The problem with the current reporting requirements has less to do with the domains but rather with the measures themselves. PQRS currently allows reporting on a raft of measures of varying usefulness and validity, which may divert providers' attention from efforts to make culture and work process improvements that could produce larger improvements in outcomes. CMS should instead be emphasizing performance measures more strategically, and investing in ways to identify and implement measures that produce meaningful and actionable information.

- *Should we require that certain types of measures be reported? For example, should a minimum number of measures be outcomes-based? Should more weight be assigned to outcomes-based measures?*

Patients, payers, policymakers and providers all care about the end results of care, not the technical approaches that providers may adopt to achieve desired outcomes. Certain process measures, like preventive screening measures, are important and can have a direct positive impact on patient outcomes. Other process measures are not strong predictors of outcomes that matter and may divert attention from work process improvements that would actually improve outcomes. Not all outcomes measures, however, have proven effective at producing information that is meaningful to stakeholders or actionable for providers. More work needs to be done here.

- *For the CAHPS for PQRS reporting option specifically, should this still be considered as part of the quality performance category or as part of the clinical practice improvement activities performance category? What considerations should be made as we further implement CAHPS for all practice sizes? How can we leverage existing CAHPS reporting by physician groups?*

NRHI believes that patient experience reporting should be mandatory for all practice sizes. To achieve this, CAHPS or other similar options would likely need to remain part of the quality performance category. But beyond just reporting, however, physicians should have incentives to use patient experience information to improve their practices. As such, the clinical practice improvement performance category should recognize

activities that help physicians understand the information and identify and implement strategies to improve.

One challenge CMS should consider is alignment. Physician practices should not have to report on patient experience through multiple, separate reporting mechanisms. This will inhibit the ability to compare and differentiate the results and also creates a survey burden. CMS should work within its own programs and with states to achieve alignment here. For instance, reporting at the practice level should be able to flow up to the larger group and ACO level, and satisfy other reporting obligations.

Resource Use Performance Category

As purchasers, like Medicare, are increasingly demanding accountability for costs and seeking to differentiate among providers and practices that manage resources effectively, providers are challenged not only to understand and manage their own costs, but also the costs of other providers. Providers entering risk-based payment arrangements need transparent cost and utilization data to be successful in managing population health and costs. To date, however, a lack of transparency regarding cost of care information has stymied achievement of meaningful payment reform. Purchasers and providers seeking accountability for costs must first know what those costs are. As CMS works to develop and improve resource use measurement, we encourage the agency to look to the work NRHI and its members are already doing in designing measures that are meaningful to, and trusted by, stakeholders in their communities. Some of this work is described more fully below.

NRHI offers the following response to CMS' specific questions on the resource use performance category:

- *Apart from the cost measures noted above, are there additional cost or resource use measures (such as measures associated with services that are potentially harmful or over-used, including those identified by the Choosing Wisely initiative) that should be considered? If so, what data sources would be required to calculate the measures?*

As CMS considers new measures of cost, we encourage it to focus on measures that have been or can be tested through multi-stakeholder collaboration. Several NRHI members were part of the Choosing Wisely campaign, and played a critical role in facilitating discussions among providers, employers and patients on unwarranted medical procedures, and guiding the development and implementation of localized, collective versions of the campaign. In fact, NRHI was selected as a Support and Alignment Network for High-Value Care under the Transforming Clinical Practices Initiative, and part of its charge will be testing additional methods for implementing Choosing Wisely recommendations through a set of provider pilots. If CMS is considering adding new measures associated with services identified through the Choosing Wisely campaign, we urge CMS to look to NRHI, the RHICs involved in the Choosing Wisely campaign, and other multi-stakeholder collaboratives with access to multi-payer claims data, to pilot any new measures at the regional level.

NRHI also encourages CMS to consider the Total Cost of Care and Resource Use (TCoC) framework developed by HealthPartners and endorsed by the National Quality Forum (NQF), as a potential next step in resource use measurement. TCoC is an analytical tool that measures cost and resource use for virtually all care used by individuals and is designed to support affordability initiatives, to identify instances of overuse and inefficiency, and to highlight cost-saving opportunities. In 2013 the Robert Wood Johnson Foundation (RWJF) funded five RHICs to measure TCoC using multi-payer commercial data, engage stakeholders, publicly report the measures associated with primary care physician practices or groups by December 2014, and work collaboratively with each other. RWJF also funded NRHI to lead and coordinate this effort to test a standardized TCoC approach in multiple regions and establish national benchmarks for cross-regional analysis.

The pilot was a success, with each region producing and distributing attributed practice level reports in their respective communities, and NRHI and the five pilot RHICs were awarded a renewal grant through October 31, 2016. But the lack of Medicare data has been a barrier to engagement for many providers whose largest group and highest cost patients are enrolled in Medicare. Phase II of the TCoC pilot has a work stream to explore how to report TCoC on the Medicare and Medicaid population. Beginning next year, MACRA will allow use of fee-for-service Medicare data by Qualified Entities (QEs), which include the participating RHICs. NRHI looks forward to working with CMS in this expansion of the QE program, and will look to CMS to support the infusion of Medicare data into the TCoC work that is already ongoing.

- *How should CMS consider aligning measures used under the MIPS resource use performance category with resource use based measures used in other parts of the Medicare program?*

CMS should consider a regional approach and process for aligning resource use measurement across Medicare programs and payment models. This approach should bring providers to the table to negotiate with other stakeholders and policy makers on measures appropriate across settings and programs. This same approach can be used to identify alignment strategies across public and private payers.

Clinical Practice Improvement Performance Category

NRHI and many of its members are actively engaged in identifying and implementing activities designed to improve clinical practice and care delivery, and in many cases also measuring how those activities are improving outcomes or lowering costs. Many NRHI members have long histories of working directly with providers on a variety of practice improvement activities. These RHICs operate programs designed to improve the way that physicians, nurses, hospital administrators and other health care professionals deliver care, such as: identifying and disseminating best practices in care delivery; providing affordable training, coaching and technical assistance to practitioners on ways to analyze problems in care delivery and ways to

design and successfully implement solutions; and helping health care providers reorganize and modernize their operations to support better-quality, more affordable care.

Given the significant investments CMS, as well as state governments and private organizations, have made in practice improvement initiatives, CMS should seek to align the CPI performance category with existing initiatives. We encourage CMS to consider the following alignment strategies:

Align CPI activities with other federal, state and regional initiatives. Quality improvement support is critical for providers, but too many initiatives or programs can overwhelm or confuse providers, and also waste resources. CMS should aim to consolidate CPI activities around existing initiatives. For instance, CPI activities should include participation in TCPI, State Innovation Model (SIM) funded activities, and other private initiatives being implemented across the country. Efforts should also be aligned with other Medicare programs, like the Hospital Engagement Network.

Align CPI activities with other roles created in MACRA, including technical assistance for small practices and physician feedback report dissemination. NRHI views “technical assistance” as including not only technical support in satisfying reporting obligations, but also guidance and assistance in understanding cost and quality data, identifying improvement goals and helping providers make the changes necessary to achieve those goals. In other words, activities that qualify as technical assistance should also qualify as CPI activities, and entities providing technical assistance to small practices under MACRA should also be recognized as qualified to offer CPI activities. NRHI also sees potential alignment between CPI activities and the provision of performance feedback under MIPS and through APMs.

Align CPI activities across the country to facilitate shared learning. Getting physicians to participate in a CPI activity should not be an end in itself. Rather, CPI activities should be focused on collaboration. Regional coordination of CPI activities would enable identification and dissemination of best practices, and would also reduce the proliferation of duplicative or ineffective activities.

In addition to these alignment strategies, NRHI offers the following responses to CMS’ specific questions on the CPI performance category:

- *Should EPs be required to attest directly to CMS through a registration system, Web portal, or other means that they have met the required activities and to specify what activities on the list they have met? Or alternatively, should qualified registries, QCDRs, EHRs or other health IT systems be able to transmit results of the activities to CMS?*

QCDRs should be able to transmit results of CPI activities directly to CMS, especially if participation in a QCDR will be considered a CPI activity. Further, to the extent CPI activities are offered or coordinated through RHICs, CMS may want to look to RHICs to

provide documentation on clinician participation (either directly to CMS or through a QCDR).

- *What threshold or quantity of activities should be established under the clinical practice improvement activities performance category?*

CMS should consider modeling CPI on SIM frameworks and maintenance of certification programs. For instance, providers could earn credits based on level of participation. Providers that make the greatest commitment and/or are able to demonstrate results from the activity should be eligible for more credit.

- *What best practices should be considered to develop flexible and adaptable clinical practice improvement activities based on the needs of the community and its population?*

One of our core principles is that practice transformation has to start at the local or regional level. Approaches to transformation will necessarily need to be different in different parts of the country since there are significant variations in the structure of healthcare and in the specific types of quality and cost problems in each community. These factors make it highly unlikely that any one-size-fits-all national solution will work.

Moreover, since the healthcare stakeholders in a community—consumers, physicians, hospitals, health plans, businesses, government, etc.—will be affected in important ways, each stakeholder needs to be involved in planning and implementing changes. In many communities, there is considerable distrust between different stakeholder groups, pointing to the need for a neutral facilitator to help design “win-win” solutions.

Many communities across the country recognize that RHICs are an ideal mechanism for developing coordinated, multi-stakeholder solutions to transform how healthcare is delivered and paid for. An RHIC does not deliver health care services directly or pay for such services; rather, it provides a neutral, trusted mechanism through which the community can plan, facilitate and coordinate the many different activities required for successful transformation of its healthcare system. We envision RHICs playing a key role in offering and coordinating CPI activities based on the needs of their communities, and working with other NRHI members across the country to identify best practices.

Other Measures

- *What types of global and population-based measures should be included under MIPS? How should we define these types of measures?*

Population-based measures should track more than just the practice of population-based medicine (i.e., process-based measures like use of a clinical registry), but should also measure how effectively providers are at managing the health of their patients. Patient-reported outcomes should be recognized as a component of MIPS.

- *What data sources are available, and what mechanisms exist to collect data on these types of [global and population-based] measures?*

For true population health management and reductions in cost, data contributions from a broad spectrum of payers, care and community based providers, public health and social service agencies, long-term care and others will be necessary to be able to measure the quality and efficiency of care delivery and health outcomes across settings of care and time. NRHI is currently leading, along with the Pacific Business Group on Health, an initiative – the Center for Healthcare Transparency – that is working squarely in this space.

Feedback Reports

Performance feedback is critical to performance improvement. NRHI members have significant experience taking performance feedback and using it to educate providers on the meaning of the data and develop strategies to improve. For instance, several NRHI members partnered with CMS in the Comprehensive Primary Care Initiative and were involved in working directly with practices to analyze their performance results. What they found was that providers did not find the reports useful in terms of changing practice behaviors. Rather, it was when these RHICs met face-to-face with the providers and helped them interpret the reports that the data took on meaning. Working directly with providers, these RHICs were able to facilitate strategy development in a way that met the unique needs of each practice.

NRHI offers the following response to CMS' specific questions on performance feedback reports:

- *What types of information should we provide to EPs about their practice's performance within the feedback report? For example, what level of detail on performance within the performance categories will be beneficial to practices?*

Providers should have access to regional data that allows them to compare their own practices to those of their peers. Providers would get an even fuller picture of their performance if their feedback incorporated multi-payer data. We therefore believe that RHICs, which have access to data from multiple payer sources, are uniquely positioned to deliver meaningful feedback to providers in their regions. Experience has shown that RHICs are in the unique position to effectively utilize multi-payer regional data to generate cost and quality information comparable basis. The data sets are developed and provider directories maintained so that comparisons can be made within geographic regions of care, to the level of the physician practice or medical group. CMS should consider ways to integrate RHICs into the physician feedback system, and in particular should look to leverage QEs and QCDRs to deliver comprehensive feedback.

- *What other mechanisms should be leveraged to make feedback reports available? Currently, CMS provides feedback reports for the PQRS, VM, and the Physician Feedback Program through a web-based portal. Should CMS continue to make feedback available*

through this portal? What other entities and vehicles could CMS partner with to make feedback reports available? How should CMS work with partners to enable feedback reporting to incorporate information from other payers, and what types of information should be incorporated?

CMS should consider partnerships with RHCs to make feedback reports available to physicians and/or incorporate regional cost and quality data from other payers. Many RHCs are already working with providers to deliver feedback on cost and quality performance, and to help these providers use the feedback for quality and performance improvement purposes. Working with providers on a continuing basis throughout the year also allows RHCs to show providers benchmark progress toward quality goals. Also, to the extent RHCs are awarded funding to provide technical assistance to small practices, CMS should channel performance feedback through these contracted partners.

- *Who within the EP's practice should be able to access the reports? For example, currently under the VM, only the authorized group practice representative and/or their designees can access the feedback reports. Should other entities be able to access the feedback reports, such as an organization providing MIPS-focused technical assistance, another provider participating in the same virtual group, or a third party data intermediary who is submitting data to CMS on behalf of the EP, group practice, or virtual group?*

Organizations providing technical assistance to providers should have access to the feedback reports and, ideally, the data underlying the reports. Likewise, when an entity like a QCDR submits data to CMS on behalf of providers, physicians should be able to elect to receive feedback through that same entity.

- *What types of information about items and services furnished to the EP's patients by other providers would be useful? In what format and with what frequency?*

Having meaningful comparative data within a region – at the practice level – will actually give physicians the information they need to play a key role in quality improvement and cost reduction. The partnership between physicians, RHCs and other key stakeholders will provide the foundational structure through which best practices are shared, successes are recognized and lessons learned are fruitful.

Alternative Payment Models

NRHI has developed a proposal outlining partnership opportunities with CMS, each of which, we believe, is essential to the development of new physician alternative payment models and is scalable in communities across the country. These include development and refinement of new payment models, piloting alternative payment models, implementing meaningful measures, and technical assistance, education and support for implementation of new payment models. A key aspect of each of these opportunities is the effective use of Medicare data (along with data

from other payers) to identify opportunities for improvement and care redesign and also determine the impact of the model on spending and quality of care.

A defining strength of many RHICs is their access to multi-payer data and their experience using the data for improvement. This will be greatly enhanced by the pending changes to the QE program allowing expanded uses of Medicare data for private reporting. In addition to having access to this valuable data, RHICs have expertise in conducting meaningful analytics and making the data actionable for providers. With these capabilities, NRHI members are poised to build the capacity to implement new measures for APMs at the regional level and to design data systems that will enable flexible reporting on priority measures.

NRHI offers the following response to CMS' specific questions on alternative payment models:

- *What criteria could be considered when determining "comparability" to MIPS of quality measures used to identify an eligible APM entity?*

In order to compare the effectiveness of APMs, we believe that a common set of quality metrics needs to be developed and drive all reporting. In the absence of a national measurement set, RHICs could provide comparative measurements for APMs. RHICs can leverage regional claims data from multiple sources to paint a more complete picture of how effectively multi-payer APMs are managing their populations.

Technical Assistance

We believe that in creating a formal technical assistance program, Congress explicitly recognized the extra help that small and rural practices will need in this new payment environment. This extra help is critical to implementing and sustaining meaningful delivery system and payment reform without leaving these practices behind. The legislative language explicitly mentions quality improvement organizations, regional extension centers and regional health collaboratives as "appropriate entities" to offer this assistance. Every NRHI member fits into one or more of these categories, and we believe this is an excellent opportunity to use our members' skills, breadth of experience and relationships with providers in their communities to implement MACRA's new payment system in a coordinated fashion.

We recognize that improvements in quality, efficiency and patient satisfaction are achieved through the actions of frontline healthcare workers. We also recognize that there are many barriers, such as lack of resources and data infrastructure, that have prevented health care providers from fully embracing opportunities to improve quality and reduce costs. As public and private payers increasingly require reporting and adjust payment based on complex metrics, failure to participate in performance based initiatives can carry significant financial consequences for providers. Smaller practices are particularly at risk as compared to larger or system-based practices that already have the resources and data infrastructures to support performance reporting and improvement activities. Overcoming these barriers requires not only a coordinated approach but, importantly, one that allows for variation to address different markets and delivery structures and cost and quality challenges in different parts of the country.

NRHI members recognize these challenges and have been working collaboratively with stakeholders in their communities to understand barriers and coordinate workable approaches to meet new value-based goals.

RHICs serve as a mechanism for developing coordinated, multi-stakeholder solutions for regional health care cost and quality problems, and provide a trusted platform through which a community can plan, facilitate and coordinate the different activities required for successful transformation of its healthcare system.

- *What should CMS consider when organizing a program of technical assistance to support clinical practices as they prepare for effective participation in the MIPS and APMs?*

A key consideration for CMS is alignment with other initiatives. CMS should look for ways to coordinate activities and consolidate resources at a state or regional level. We encourage CMS to consider the following alignment strategies:

1. *Align technical assistance with other federal, state and regional initiatives.* Technical assistance will be critical for small and rural practices, but too many initiatives or programs can overwhelm or confuse providers, and also waste resources. CMS should aim to consolidate technical assistance around existing initiatives, such as TCPI or SIM activities.
2. *Align technical assistance with other roles created in MACRA,* including CPI activities and physician feedback report dissemination. NRHI views “technical assistance” as including not only technical support in satisfying reporting obligations, but also guidance and assistance in understanding cost and quality data, identifying improvement goals and helping providers make the changes necessary to achieve those goals. In other words, activities that qualify as technical assistance should also qualify as CPI activities, and entities providing technical assistance to small practices under MACRA should also be recognized as qualified to offer CPI activities. NRHI also sees potential alignment between technical assistance, CPI activities and the provision of performance feedback under MIPS and through APMs.
3. *Align technical assistance across the country to facilitate shared learning.* Getting physicians to participate in a technical assistance program should not be an end in itself. Rather, technical assistance should be focused on collaboration and learning. Regional coordination of technical assistance through RHICs, supported by NRHI as a national support network, would enable identification and dissemination of best practices and would also reduce the proliferation of duplicative or ineffective activities. Again, this could be aligned with the existing TCPI framework, under which NRHI is acting as a Support and Alignment Network.

CMS should also consider incorporating some core elements such as practice readiness assessments, creating clear milestones and periodic feedback (e.g., weekly/monthly progress calls).

- *What existing educational and assistance efforts might be examples of “best in class” performance in spreading the tools and resources needed for small practices and practices in HPSAs?*

NRHI has countless examples of regional efforts led by RHICs that are driving change in their communities. Many RHICs work directly with providers on a variety of practice transformation activities. RHICs operate programs designed to improve the way that physicians, nurses, hospital administrators and other healthcare professionals deliver care, such as: identifying and disseminating best practices in care delivery; providing affordable training, coaching and technical assistance to practitioners on ways to analyze problems in care delivery and ways to design and successfully implement solutions; and helping healthcare providers reorganize and modernize their data systems and operations to support and sustain better-quality, more affordable care.

Underlying the success of each of these initiatives is multi-stakeholder collaboration. There is no “one-size-fits-all” approach to practice transformation, which is why stakeholders and states are increasingly looking to RHICs to guide payment reform in their communities. Each RHIC establishes its own direction through consensus among its members.

Below are some specific examples of the work NRHI members are doing in their regions, which could be leveraged to support small and rural practices:

- The Health Collaborative was selected as a participant by the Center for Medicare and Medicaid Innovation in the Comprehensive Primary Care Initiative. They organization was tasked with providing technical assistance to the 75 participating primary care practices through on-site practice support, actionable data reports based on Medicare fee-for-service data, care manager educational forums and sharing best practices as providers work to enhance patient experience, improve access to care and engage in more coordinated, patient-centered care management. The Health Collaborative also serves as a tri-state regional extension center to help practices, hospitals and health systems navigate the process of implementing electronic health records, establishing meaningful use of health information technology and qualifying for incentive payments.
- The Pittsburgh Regional Health Initiative (PRHI) is one of the nation’s first regional collaboratives of medical, business and civic leaders organized to address quality improvement and safety as both a social and business imperative. Since its founding in 1997, the PRHI has pioneered a lean-based quality improvement methodology for healthcare—Perfecting Patient CareSM. To spread quality and reduce costs, PRHI serves as a neutral convener, tests new models of care and offers in-person, online and collaborative training and coaching to healthcare organizations. PRHI’s work with frontline healthcare teams is guided by findings from PRHI’s data analyses and spans the settings of

healthcare, including small and large primary care centers. This work currently includes quality improvement, readmission reduction, EHR implementation and Meaningful Use, workflow redesign, care management, motivational interviewing, patient-centered medical homes, consumer activation, and behavioral and physical healthcare integration.

- The Institute for Clinical Systems Improvement (ICSI) works with its provider members to build quality improvement skills through education, practice facilitation and individual projects. ICSI trains members in quality improvement, measurement, goal-setting, team-based care, and adaptive and technical approaches, and coaches them through an initial project so that they are ready to participate in future improvement projects. ICSI provides education and mentoring for implementation and facilitation of the project, working with the organizations leadership, project managers and teams to determine objectives, measures, support for implementation of changes, evaluation, data analysis, strategic planning and sustainability planning.
- HealthInsight is currently providing technical assistance for providers in a Patient Centered Medical Home Pilot, and it successfully assisted seven clinical practices in becoming NCQA recognized medical homes. Technical assistance included workflow assessments, implementation of the IHI Model for Improvement, staff training to increase understanding and practice of adoption of evidence-based guidelines, chronic disease management, changing workflow to capture all necessary EHR documentation, enhancing practice management and revenue through optimizing billing and coding for care transitions and formalizing referral management processes. These practices subsequently gained the infrastructure to improve in quality improvement initiatives, participate in numerous payer incentive programs resulting in significant revenue increases, recruit new patients through improved word of mouth reputations, retain staff and establish the requisite infrastructure to succeed in new payment methods and models.
- The Louisiana Health Care Quality Forum, through its roles as administrator of the Louisiana Health Information Technology Resource Center, the state's Regional Extension Center, and the Louisiana Health Information Exchange, is also helping physician practices become patient-centered medical homes, implement electronic health records and more effectively coordinate care with other providers. It is currently engaged in a project helping parish health clinics implement electronic health records, and provides live technical assistance and guidance to the parish health units to ensure that all staff and medical personnel receive accurate, efficient support. It is also working with healthcare providers across the state using its unique and innovative model that combines health information technology with practice transformation coaching. It utilizes clinical practice consultants to provide assistance to practices in understanding the data available in implementing interventions to improve healthcare outcomes.

- The Wisconsin Health Information Organization maintains a data mart that it makes available to providers to identify opportunities to make improvements in the care and services they provide to Wisconsin citizens. The data can be used, for example, to identify gaps in care for treatment of chronic conditions and provide real-world data about the costs per episode of care, population health, preventable hospital readmissions and variations in prescribing generic drugs.
- The Wisconsin Collaborative for Healthcare Quality (WCHQ) operates a clinical data repository that enables its 40 member physician organizations to electronically submit global billing and clinical data files for use in generating valid and reliable performance measures to drive both external reporting and internal quality improvement. With over 12 years of experience in gathering data directly from physician practices, WCHQ leveraged this core competency to become the only RHIC in the country to be designated by CMS as a QCDR for purposes of submission of data under the PQRS and MU reporting programs. WCHQ also convenes and facilitates collaborative learning events designed to bring providers together with other stakeholders to share “best practices” in improving quality, lowering costs, and promoting health.
- The Maine Health Management Coalition and Maine Quality Counts have partnered with the Maine Quality Forum to lead the multi-payer Maine Patient Centered Medical Home pilot. In 2012, CMS selected Maine as a recipient of the Multi-payer Advanced Primary Care Practice demonstration program, which runs until 2016. Through the program, these RHICs work with participating pilot practices to meet program criteria and achieve certain performance benchmarks.

RHICs are also pioneering the use of health care claims data to support clinical practice transformation. A number of NRHI members have been collecting and publicly disseminating measures related to the quality and cost of healthcare services in their communities, partnering with payers to access and analyze claims data. When the Affordable Care Act created the Qualified Entity program to provide Medicare claims data to a select number of entities for provider performance analysis, several RHICs stepped up to fill this role and now have access to transformative data. Today, 10 of the 12 Qualified Entities are NRHI members. With the recent changes MACRA made to the QE program, QEs will now have the ability to use Medicare data to work directly with healthcare providers to help them understand and improve their performance and transform how they are delivering care in their communities. This is a function that we believe would complement the technical assistance program, and QE performance improvement activities should be aligned with measurement and payment under the new payment systems.

- *What are the most significant clinician challenges and lessons learned related to spreading quality measurement, leveraging certified EHR technology to make practice*

improvements, value based payment and APMs in small practices, and what solutions have been successful in addressing these issues?

There are many barriers to spreading quality measurement, leveraging certified EHR technology and implementing value-based payment reforms. Among the most significant are the lack of alignment with ongoing health plan imperatives or quality initiatives, the lack of financial resources to make costly changes or take on risk and a lack of actionable data to inform practice changes. Further, federal funding for Regional Extension Centers was inadequate to meet the needs of many small rural practices.

For quality measurement and payment reform to be attainable to small practices and meaningful to other stakeholders, there needs to be some level of investment in building consensus around the aims, measures and methods of spreading change. In addition to a neutral facilitator to ensure assure consensus, there also needs to be a neutral source of data with the expertise needed to produce fair and unbiased analytics. Access to data, ideally regional multi-payer data, is critical to help small practices understand their own costs, as well as the costs attributed to them for services rendered by other providers. Further, for practices to leverage EHR technology to make practice improvements, they need more regional support.

- *Should such assistance require multi-year provider technical assistance commitment, or should it be provided on a one-time basis?*

In the collective experience of our members, sustained assistance is critical to achieve any change in behavior. We would recommend a minimum commitment of 18 months. CMS should permit multi-year contracts with technical assistance entities which also allow for renewal.

- *Should there be conditions of participation and/or exclusions in the providers eligible to receive such assistance, such as providers participating in delivery system reform initiative such as the transforming clinical practice initiative?*

As described above, we believe CMS should be aligning the various initiatives to the extent possible. As such, entities participating in the TCPI should be eligible to provide technical assistance. For providers, CMS should avoid duplication and exclude those that are already receiving funded technical assistance through other initiatives.

Conclusion

As CMS develops the levers it will use to implement MACRA's payment reforms, we encourage it to look to past successes and present innovation happening at the state and regional level. To the extent that CMS can consolidate two or more of its levers within one organization or a network of aligned organizations, implementation will be more efficient and manageable for providers and for CMS. NRHI urges CMS to seek ways to align and integrate these various roles

at the local or regional level, avoid duplication of efforts and coordinate activities to promote shared learning.

Our work has taught us collaboration across states and regions is highly valuable in implementing goals and accelerating progress. An evaluation of the TCoC project by Health Management Associates (HMA) in September 2015, for instance, highlighted the importance of: allowing sufficient time for planning and stakeholder engagement; incorporating technical assistance to assure data quality; seeking physician input and feedback for making TCoC reports actionable; and collaborating with other RHICs to accelerate progress. The HMA report further stated: **“These lessons may be applied to expanding TCoC efforts as well as to other regionally-based health care transparency and reform initiatives.”** There are more than 30 RHICs covering markets that include approximately 40 percent of Americans, and new or nascent collaboratives are still forming. The regional implementation model that has been successful in the TCoC and other pilots can and should be replicated for various aspects of MACRA implementation.

NRHI appreciates the opportunity to respond to this RFI, and looks forward to participating in the implementation of MACRA.

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