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June 27, 2016

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

**Re: Response to CMS-5517-P, Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed Rule**

Dear Acting Administrator Slavitt:

The Network for Regional Healthcare Improvement (NRHI) appreciates the opportunity to respond to the above-referenced Proposed Rule. NRHI is a national organization representing over 35 Regional Health Improvement Collaboratives (RHICs) with footprints extending into 25 states across the country. Some states have more than one RHIC, and some RHICs span multiple states. Nineteen are statewide, and 15 are regional. All RHICs share a common mission – to improve health and healthcare in communities across the U.S. through an active and engaged network. Within their communities, each RHIC is working to transform the healthcare delivery system and achieve the Triple Aim: improving the patient experience of care, including quality and satisfaction; improving the health of populations; and reducing the per-capita cost of healthcare.

The Medicare program, as the single largest payer for healthcare in the United States, has an outsized interest in delivering high quality care at a low cost, and has adopted Triple Aim goals as part of its national strategy. Because of these shared objectives, NRHI members have forged successful partnerships with the Centers for Medicare & Medicaid Services on a variety of initiatives. For instance, our network includes 10 of the 15 Medicare Qualified Entities; five Quality Improvement Organizations/Networks; five health information exchanges (HIEs) and one Qualified Clinical Data Registry (QCDR). Ten of the RHICs are currently or have been Choosing Wisely grantees, and three are Practice Transformation

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Networks (PTNs) in the Transforming Clinical Practices Initiative (TCPI). Nine of NRHI's members are partners in AHRQ's Centers of Excellence for Patient Centered Outcomes Research. Collectively through both public and private initiatives, NRHI members are providing programs to support improved healthcare for over 35 percent of the US population. NRHI itself is partnering with CMS as a Support and Alignment Network for the TCPI.

Just as the Affordable Care Act (ACA) transformed the coverage landscape, MACRA is transforming the way physician services are delivered and paid for. And, as is the case with the ACA, implementation of MACRA will require significant outreach and education, and there will be obstacles for the agency along the way. Clinician readiness is a significant and immediate issue, particularly for solo practitioners and small physician practices. Congress provided some funding for outreach to small and rural practices, but this should be viewed as just one part of a broader strategy to reach small practices and preserve their ability to serve their communities.

NRHI and its members look forward to new opportunities to partner with CMS on initiatives and activities arising under the Medicare Access and CHIP Reauthorization Act (MACRA). We appreciate the challenges CMS faces in implementing this vast new payment system. Below we offer comments on how RHICs can assist in meeting many of these challenges.

## I. Comments on achieving short and long-term objectives

At a high level, we view MACRA as an opportunity to support practice transformation that will benefit all healthcare consumers, not just Part B beneficiaries. MACRA establishes financial incentives to spur practice transformation. But, as CMS recognizes, these incentives are only effective if clinicians have the right tools and resources, and the support of other healthcare stakeholders in their communities. Disseminating these tools and resources is a real and immediate challenge, particularly in the case of smaller practices that may not be as engaged in current value-based payment initiatives. CMS should look to RHICs as accelerators for getting tools into the hands of relevant stakeholders and facilitating transformation for communities as a whole, because:

a. **RHICs have existing relationships with clinicians and other stakeholders in their communities.** RHICs are trusted local conveners and on-the-ground implementers of delivery system and payment reform across all payers and stakeholders. Their multi-stakeholder composition, plus their history of success in their regions, has facilitated the development of strong relationships with clinicians and others in the healthcare community. We strongly believe that CMS should turn to RHICs to leverage these existing relationships in order to meet its objectives. Building trust takes time, even more so when payments are involved, and trust is the cornerstone of RHICs existence in their community. . These existing relationships are especially critical for the early years of MACRA, given the rapidly approaching performance year and the lack of preparedness among smaller practices.

**b. RHICs have data.** RHICs have access to transformative data (claims, clinical and patient experience data from multiple payers), and the analytic capabilities to measure and report on performance.

**c. RHICs play quality improvement roles**. Many RHICs are already engaging with providers in their communities on quality improvement. Their ability to analyze data and report on provider performance, and help providers and stakeholders to understand and use the data, underlie these QI activities.

RHICs are well-positioned to help CMS meet both short-and long-term objectives by quickly and efficiently disseminating the tools necessary for transformation – relationships, data, and QI – across the front lines of healthcare delivery. Our members are hearing from providers in their regions that they are already overwhelmed and confused by the number of entities offering technical assistance through various state and federal programs. A streamlined and comprehensive approach to technical assistance will help to eliminate confusion, and ultimately benefit patients.

In the comments that follow, we endeavor to highlight some specific ways in which RHICs can be built into the new Quality Payment Program

## II. Comments on the Merit-Based Incentive Payment System and APM Incentive proposals

### a. CMS should create a regulatory definition of a Regional Health Improvement Collaborative to implement new Social Security Act § 1848(q)(11)

Section 101 of MACRA (at new Social Security Act § 1848(q)(11)) directs the Secretary to establish a technical assistance program for small practices and practices in health professional shortage areas to help these practices with their MIPS performance, as well as guide them in how to transition to the implementation of and participation in alternative payment models. The statute also directs the Secretary to contract with entities such as "quality improvement organizations," "regional extension centers," and "*regional health collaboratives*." While quality improvement organizations and regional extension centers are terms already defined in regulation, regional health collaboratives are not. Therefore, CMS should adopt a definition of a regional health collaborative (or, preferably, a regional health improvement collaborative to maintain consistency with current usage). As the national membership organization for RHICs, we propose the following definition:

> A non-profit organization based in a specific geographic region that is
>
> (1) governed by a multi-stakeholder board that must have representation from four types of stakeholders: (a) health care providers (hospitals, physician groups, physicians, home health agencies, nursing homes, clinics, etc.); (b) health care payers (private health insurance plans, state Medicaid agencies paying directly for care, etc.); (c) health care purchasers (employers, unions, retirement funds, and

government entities); and (d) health care consumers or consumer organizations; and

(2) whose mission is to improve healthcare quality and value through an active program of quality measurement and public reporting, or an active program of quality improvement, or both; through a collaborative effort of healthcare providers and other stakeholders; and

(3) helps stakeholders in the community identify opportunities for improving the health and healthcare of the community, and facilitates planning and implementation of strategies for addressing those opportunities.

Throughout our remaining comments, we offer specific examples of where CMS should weave RHICs into the MACRA infrastructure beyond the technical assistance program for small and rural practices. In fact, RHICs are already doing work that matches some of the roles that MACRA creates, such as performance feedback and clinical practice improvement activities. NRHI sees significant opportunities to align our pre-MACRA work with MACRA implementation and sustainability efforts.

b. **Quality Measurement: CMS should work with RHICs to pilot ways to incorporate multi-payer claims and clinical data into reporting mechanisms, and support regional data aggregators engaged in measurement and public/private reporting**

NRHI supports CMS' proposals to use all-payer data where possible, recognizing that this data will create a more comprehensive picture of a practice's performance. Specifically, we support the proposal to include all-payer data for the Qualified Clinical Data Registry, qualified registry, and EHR submission mechanisms. We also support CMS' proposal to award bonus points to incentivize reporting on measures developed through sources, like EHRs and QCDRs, which draw from a rich set of clinical data and can reduce data collection and reporting burden while providing the opportunity to support more timely performance feedback to clinicians than is possible through manual claims submission.

We believe that CMS can do more to incorporate all-payer data and advance the reporting of clinical data. Along these lines, we urge CMS to break down the data silos that currently exist, and enable data sharing through regional data intermediaries that can aggregate claims data, clinical data, and patient experience data across payers. Our members are uniquely positioned to fill this role. Five of our members lead Health Information Exchanges, and one operates a QCDR, and thus have access to clinical data, in addition to claims data. Further most RHICs have access to multi-payer claims databases and many combine claims data from multiple commercial payers and Medicaid to measure and analyze the quality and cost of healthcare in their communities, and those that are QEs have access to Medicare claims data as well. As mentioned above, 10 of our members are QEs, with one additional member just starting the application process, and have been deemed, through a rigorous approval process, capable of combining Medicare claims data with claims data from other sources for performance

measurement and reporting purposes.[1] RHICs can assist CMS in achieving its goal to include regional multi-payer claims data[2] that also captures clinical data, and can serve as a neutral third party data aggregators to help practices measure and improve performance, and publicly report on performance.

Multi-payer data sources will become even more critical in future years of the Quality Payment Program, as participation thresholds for those seeking Qualified APM Participant ("QP") status increase to levels that many organizations say will be challenging to attain. To meet these levels, organizations will need to demonstrate participation in "Other Payer APMs" in order to receive the APM Incentive Payments. Current data flows, like the Quality and Resource Use Reports, will be insufficient to enable these practices to manage their full patient populations. CMS therefore needs to supplement traditional reporting mechanisms with multi-payer claims and clinical data, such as through Total Cost of Care reporting (described below).

**c. Quality Measurement: CMS should move toward adopting a common set of measures.**

Allowing clinicians to select from a large menu of comparable measures can serve important quality improvement purposes. But for purposes of holding clinicians accountable for the quality of care they provide, there needs to be a set of standardized measures that enable meaningful benchmarks and allow for comparisons across regions. A lack of alignment will lead to a lack of accountability, and will also make it difficult for CMS (or employers, providers, consumers or plans) to meaningfully differentiate between high value and low value providers for purposes of awarding financial incentives.

A small number of high-priority measures, including patient-reported outcome measures, should be identified for targeted implementation across regions to prepare for national scale and use. Ideally, these measures would be tested through multi-stakeholder organizations like RHICs, that have extensive experience working within their communities to test measures and identify those that are trusted and meaningful to providers, payers, employers and consumers.

**d. Resource Use Measurement: CMS should continue to emphasize total cost measures for the MIPS payment adjustment, but should give providers tools to supplement this information and create actionable results**

We support CMS' proposal to incorporate more episode-based measures into the Resource Use performance category. However, we believe that CMS must continue to use total cost measures to capture the total cost picture that episode-based measures cannot provide. Total cost and

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[1] NRHI is encouraging CMS to allow QEs to share data with other RHICs in order to serve a greater number of communities. We raised this position in our comments on the Medicare Qualified Entity Program proposed rule.

[2] In our experience, regional claims databases offer a more comprehensive set of data from more payers in a particular market, as compared to national databases.

total resource use measures are essential for any payer, and especially for CMS as a large national purchaser of healthcare items and services. These measures are essential to track the overall progress of Medicare value-based purchasing initiatives and spur communities to achieve greater overall value.

On top of the claims-based measurements CMS uses for payment adjustment purposes, we strongly encourage CMS to steer providers toward tools that offer a multi-payer perspective on total cost of care. Multi-payer data better supports affordability initiatives, and more broadly identifies instances of overuse and inefficiency and cost-saving opportunities. One such tool is the Total Cost of Care and Resource Use (TCoC) framework developed by HealthPartners and endorsed by the National Quality Forum (NQF).[3] TCoC is an analytical tool that measures cost and resource use for virtually all care used by individuals, and produces more actionable data points for providers because it can drill down to lower levels of analysis than Tax Identification Number and includes certain costs not otherwise captured in other total cost measures. A TCoC measure is also important to private payers, because it can identify instances where providers may be shifting costs to other payers or service lines as a result of MACRA.

CMS should encourage providers to access these types of performance reports to supplement the information they receive from CMS on just their Medicare Fee for Service claims. For valid measurement and reporting, certain member thresholds need to be met. When multi-payer data sets are utilized, the likelihood of reporting to more practices, especially smaller practices, increases given the larger number of patients that can be attributed. One way to do this would be to allow clinicians to elect to receive their performance feedback through RHICs that are able to provider a multi-payer perspective. This election could also count as a clinical practice improvement activity (described below).

**e. Clinical Practice Improvement Activity (CPIA) Performance Category: CMS should align CPIA across the country to facilitate shared learning and prevent against waste and inefficiency, and should create a "single source" option for providers for reporting, measurement benchmarking and feedback, that also counts toward the CPIA performance category**

[3] 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. This effort was expanded in 2015 and now includes 11 regions across the country actively working toward reporting TCoC in their regions.

Getting physicians to participate in a CPIA should not be an end in itself. Rather, CPIA 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. Quality improvement support is critical for providers, but too many initiatives or programs can overwhelm or confuse providers, and also waste resources.

An optimal approach is for CMS to thoughtfully link CPIA with the measurement, reporting, and benchmarking functions performed by RHICs, such as those operating QCDRs and QEs. The resulting synergy in this single source option creates efficiencies that can accelerate the drive toward improved quality, lower costs, and better health.

**f. CPIA Performance Category: Participation in a RHIC should count as a CPIA**

Consistent with the comments above, CMS should count participation in a RHIC as a CPIA. MACRA directs the Secretary to consider, in establishing CPIA, the circumstances of small practices and practices located in rural areas and health professional shortage areas. As Congress recognized when identifying RHICs as appropriate entities to provide technical assistance to small and rural practices, RHICs' regional focus and multi-stakeholder governance structure allow them to engage small practices in a way that others cannot.

First, as mentioned above in the discussion of the Resource Use performance category, CMS should identify a CPIA that is focused on TCoC reporting as a supplement to other feedback. For instance, CMS should include the following as part of the Patient Safety and Practice Assessment category:

> *Engage with local RHIC to measure Total Cost of Care and identify practice improvement opportunities, create a practice improvement plan, and execute on the plan.*

Second, we note that many of the proposed CPIAs that center on QCDR participation and Quality Improvement Organization (QIO) technical assistance could be expanded to include assistance that providers obtain through RHICs. For instance, at a minimum, the following activities should be expanded to include RHICs:

- Population Management: Take steps to improve health status of communities, such as collaborating with key partners and stakeholders to implement evidence-based practices to improve a specific chronic condition. Refer to the local QIO [*or RHIC*] for additional steps to take for improving health status of communities as there are many steps to take for improving health status of communities.

- Population Management: Use of a QCDR [*or RHIC*] to generate regular feedback reports that summarize local practice patterns and treatment outcomes, including for vulnerable populations.

- Beneficiary Engagement: Participation in a QCDR [*or RHIC*], that promotes collaborative learning network opportunities that are interactive.

- Beneficiary Engagement: Participation in a QCDR [*or RHIC*], that promotes use of patient engagement tools.

- Beneficiary Engagement: Use of QCDR [*or RHIC*] patient experience data to inform and advance improvements in beneficiary engagement.[4]

- Achieving Health Equity: Participation in a QCDR [*or RHIC*], demonstrating performance of activities for promoting use of patient-reported (PRO) tools and corresponding collection of PRO data.

We also recommend that CMS include reference to RHICs and/or Qualified Entities in the following CPIA:

- Patient Safety and Practice Assessment: Build the analytic capability required to manage total cost of care for the practice population that could include one or more of the following:

    - Train appropriate staff on interpretation of cost and utilization information; and/or

    - Use available data regularly to analyze opportunities to reduce cost through improved care; and/or

    - [*Engage with local RHIC, QCDR or Qualified Entity to perform analysis and identify opportunities*.]

- Patient Safety and Practice Assessment: Measure and improve quality at the practice and panel level that could include one or more of the following:

    - Regularly review measures of quality, utilization, patient satisfaction and other measures that may be useful at the practice level and at the level of the care team or MIPS eligible clinician or group; and/or

    - Use relevant data sources to create benchmarks and goals for performance at the practice level and panel level; and/or

    - [*Engage with local RHIC, QCDR or Qualified Entity to review measures and create benchmarks and goals*.]

[4] We offer the Massachusetts Health Quality Partners (MHQP) as an example of work being done by RHICs on beneficiary engagement. MHQP has been a leader in measuring patients' experiences since 2005, when it released its first Patient Experience Survey (PES) report. MHQP has been conducting surveys and publicly reporting the results since then, and in recent years has partnered with Consumer Reports on a special issue featuring a report entitled "How Does Your Doctor Compare?" along with a 24-page insert which provides patient experience ratings of primary care physician practices from across the state.

**g. CPIA Performance Category: CMS should include the Transforming Clinical Practice Initiative (TCPI) in the CPIA inventory, and allow PTNs to recruit Track 1 Medicare Shared Savings ACOs**

NRHI supports the inclusion of the TCPI in the CPIA inventory and its designation as a "High" weight activity. NRHI serves as a Support and Alignment Network for High-Value Care, and in this role will connect NRHI member RHICs with PTNs in their regions to provide the vehicle for supporting transformation efforts on the ground. Three RHICs are leading Practice Transformation Networks, at least four RHICs are serving as sub-contractors to PTNs, and seven are involved in NRHI's Support and Alignment Network.

In the interest of reaching a diverse array of practices and positioning practices for success in alternative payment models, we urge CMS to reconsider its policy on Medicare Shared Savings ACOs. In particular, CMS should allow PTNs to recruit Track 1 Shared Savings ACOs to facilitate their transition to a risk-bearing model.

**h. Performance Feedback: CMS should (a) work with stakeholders to create a plan for incorporating all-payer claims and clinical data into performance feedback for both the Quality and Resource Use performance categories, and (b) encourage clinicians to obtain performance feedback from organizations that have a quality improvement function.**

NRHI supports CMS' proposal to supplement the physician feedback process by leveraging third parties such as HIT vendors, qualified registries, and QCDRs to disseminate data and information to eligible clinicians. These third party mechanisms, because they include all-payer data and can better capture clinical data, allow clinicians to receive feedback on the full spectrum of their practice. CMS suggests that these third party feedback mechanisms will only be able to provide information on the quality performance category for MIPS at this time, but that it plans to coordinate with third party intermediaries to enable feedback on all performance categories as the MIPS program evolves.

We agree that it is highly desirable to offer clinicians the option to receive their performance feedback through one channel, and therefore urge CMS to make this a priority for future performance years. We also recommend that as part of this initiative, CMS work with stakeholders toward creating a channel for clinicians to view their performance on both quality *and* resource use measures across all (or multiple) payers. As CMS has recognized in its design of the Comprehensive Primary Care Plus program, a group of clinicians cannot transform their practice just for one subset of their patients. So if the goal of performance feedback is to enable practice improvement, it is critical for clinicians to have access to a resource that provides them with a complete picture of their practice across all payers.

In addition to these third party mechanisms, CMS should consider other available mechanisms such as Qualified Entities. QEs have the capability to combine Medicare and other payer data to provide practices with a more comprehensive picture of performance. Many QEs also are currently engaging with providers in their communities on quality improvement. QEs that are

RHICs (10 of the 15) have access to regional data, have regional market knowledge and relationships, and are close enough to the community that they are well-positioned to reach small providers. Current QEs are already hearing from clinicians in their regions, including those in small practices, who are eager to use QE data to inform their practices. MACRA gives QEs the ability to use Medicare data for non-public practice improvement purposes, as determined appropriate by the Secretary. CMS should similarly recognize the QE program as a mechanism to provide performance feedback, should providers wish to engage with a QE, *and* allow engagement with a QE to count as a CPIA.

**i. Quality Measurement: Selection of Quality Measures**

We offer the following comments on two specific measures proposed in Table A of the Proposed Rule and one measure included in Table D. We note that the measure stewards for these measures – Minnesota Community Measurement and the Wisconsin Collaborative for Healthcare Quality – are both NRHI members.

- Optimal Asthma Control: The included description reflects only one component of the Optimal Asthma Control measure, and not the composite measure. The accurate description for this measure (as it is in 2016 PQRS) is: "Composite measure of the percentage of pediatric and adult patients whose asthma is well-controlled as demonstrated by one of three age appropriate patient reported outcome tools and not at risk for exacerbation."

- Ischemic Vascular Disease All or None Outcome Measure (Optimal Control). We are supportive of the inclusion of all-or-none composite measures aimed at achieving optimal care for this population, however, we encourage CMS to also consider the nearly identical composite measure, Optimal Vascular Care (Table D), which includes guideline supported and evidence-based numerator exceptions for statin use.

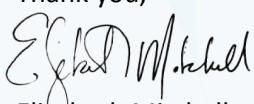
**j. Alternative Payment Models**

We encourage CMS to consider new APMs that are primary care –based and include community providers. Our members strongly believe that these models will drive population health, but are currently underrepresented in current APM options.

**Conclusion**

We appreciate the opportunity to comment in this important rulemaking process, and look forward to working with CMS to further Triple Aim goals for Medicare and the healthcare system as a whole.

Thank you,



Elizabeth Mitchell
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