Patient-Centered
Primary Care
COLLABORATIVE

March 1, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Mr. Slavitt,

On behalf of the Patient-Centered Primary Care Collaborative - a diverse membership organization representing health care providers, patients and their families/caregivers, payers, employers and purchasers - we write in response to the Center for Medicare and Medicaid Services' (CMS) request for stakeholder comments on the Draft CMS Quality Measure Development Plan, required as part of the Medicare Access and CHIP Reauthorization Act (MACRA).

Founded in 2006, the Collaborative promotes an effective and efficient health system built on a strong foundation of primary care and the patient-centered medical home (PCMH). The PCMH model embraces the relationship between primary care providers and their patients, families, and care-givers; promotes authentic communication and patient engagement; and coordinates whole-person, compassionate, comprehensive, and continuous team-based care; all of which are crucial to achieving meaningful health system transformation that improves outcomes and lowers costs. Today the Collaborative's membership represents more than 1,200 medical home stakeholders and supporters throughout the United States.

Fundamental to the Collaborative is our belief that in order for the US health system to reach its full potential, we must increase our financial support for enhanced primary care, as well as restructure primary care delivery in order to best serve the public's needs. We strongly support the Administration and Congress in their drive for health care payment and delivery system reforms that support better value for patients, providers, and payers. Specifically, we applaud the substantial commitment from the U.S. Department of Health and Human Services (HHS) to shift Medicare fee-for-service (FFS) toward value-based payment models, and Congressional passage of MACRA,[1] which when fully implemented will incentivize delivery of high quality care, align existing performance measures, and incorporate value-based reimbursement into FFS Medicare. As you are aware, the passage of the MACRA creates two payment pathways -- the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APM) -- both of which acknowledge that advanced primary care delivered through certified patient-centered medical homes are critical to advancing system-wide transformation.

As stated in the solicitation for public comment, the purpose of the CMS Quality Measurement Development Plan is to serve as a framework for the future of clinician quality development to support MIPS and APMs. The Collaborative supports the general framework for the Quality Measurement Development Plan (QMDP) as proposed, within the framework of CMS' six Quality Strategy Goals. In particular, we agree with your strategic approach to include multi-stakeholder groups to assist in generating creative solutions for use of measures across multiple payers and delivery systems, from both the private and public sectors.

In our comments, the Collaborative provides additional input on the following sections of the Operational Requirements of the QMDP:

1. **Multi-payer Applicability of Measures**
2. **Quality Domains and Priorities**
3. **Care Coordination**
4. **Patient and Caregiver Experience**
5. **Population Health and Prevention**
6. **Efficiency and cost reduction**
7. **Applicability of Measures Across Healthcare Settings**

A. Multi-payer Applicability of Measures (p. 23)

As described in the QMDP, many quality measures currently in use are duplicative, resulting in redundancy and variability that creates creates administrative burden for providers; often these measures are not meaningful to patient care. Primary care practices disproportionately feel this burden as they are increasingly being asked for performance metrics to assess their progress in providing high quality care. As an example included in the QMDP Appendix, the specialties of Family Medicine and Internal Medicine each have over three times as many Physician Quality Reporting System (PQRS) measures as other physician sub-specialties (Table 1, p. 53). The reporting measures currently required of primary care practices are myriad, including but not limited to PQRS, Meaningful Use, Value based modifiers, Maintenance of Certification, Continuing Education, and various other certification and accreditation programs, such as those required of certified patient-centered medical homes.

The lack of agreement and alignment across performance measures pose a significant and growing problem to practices. In a recent survey of family physicians, most reported submitting claims to seven or more payers (71 percent), with nearly four in 10 physicians currently submitting claims to more than 10 different payers (38 percent).[2] The overwhelming majority viewed lack of staff time as a barrier to implementing value-based care delivery (91 percent). Most agreed that the absence of coordinated data and metrics were barriers, with **75 percent citing a lack of uniform reports from payers, 75 percent mentioning lack of standardization of performance measures and metrics, and 63 percent reporting that the absence of timely data** impacted their ability to improve care and reduce costs.[2] As new quality measures are developed through MIPS, and replace existing PQRS and VBPM programs, the Collaborative urges CMS to ensure the new measures do not impose extensive administrative burden and documentation on providers, which limits time caring for and collaborating with patients and families.

Standardization of performance measures is also key function of multi-payer collaboratives -- which bring together private payers (health plans, employers, and unions), Medicaid, and more recently Medicare. Multi-payer collaboratives coordinate efforts across multiple payers without fear of anti-trust violation and provide important opportunities for shared learning of best practices at a local or regional level.[3] Early evaluations of multi-payer arrangements, including the CMS' Multipayer Advanced Primary Care Program

(MAPCP) demonstration and CMMI's Comprehensive Primary Care (CPC) initiative, demonstrate that health care providers and payers find multi-payer participation as worthwhile despite the time, effort, and investment because the re-design and alignment efforts have resulting buy-in from clinicians.[4,5]

The Collaborative encourages CMS to glean lessons learned from MAPCP and CPC as they develop and promote measure alignment as part of MACRA implementation. We strongly recommend the use of parsimonious, standardized, aligned, validated measures developed with multi-stakeholder input – such as the Measures Application Partnership -- that can be used by both public and private payers. In addition, the Collaborative supports the work of the Core Quality Measures Collaborative led by AHIP, CMS, and NQF, and encourages the adoption of core measures through the rulemaking process.

B. Quality Domains and Priorities (p. 30)

MACRA defines "quality domains" as: clinical care; safety; care coordination; patient and caregiver experience; population health and prevention; and they align with the CMS Quality Strategy goals and National Quality Strategy. CMS is proposing to include "efficiency and cost reduction" as an additional quality domain.

1. Care Coordination (p. 32)

One of the five core features of a PCMH is coordinated care, ensuring that the primary care practice organizes care across all elements of the broader health care system, including specialty care, hospitals, home health care, and community services and long term care supports. In order to improve access and convenience, PCMHs support the use of email and asynchronous communication between primary care clinicians and their patients/caregivers. Increasingly, PCMHs also offer remote monitoring or telehealth services. Finally, PCMHs offers whole-person care from a team of providers that is accountable for the patient's physical and behavioral health needs, including prevention and wellness, acute care, and chronic care. Accordingly, **the Collaborative supports the development of measures that improve communication and accountability across this range of health care providers, both primary and specialty care, based on the needs of the patient and family. We also encourage the consideration of hybrid data sources to link information between care settings, especially for disparate systems that require better integration, such as clinical and behavioral health.**

2. Patient and Caregiver Experience (p. 33)

Currently, considerable effort is underway to engage patients at the level of direct care as reflected in CAHPS and other quantitative patient experience measures. We support the development of measures that enhance the patient/caregiver experience of care delivered through integrated team-based primary care, including shared decision-making, patient self-management of chronic illness, advanced care planning, compassionate end-of-life care for patients and for family/caregivers, care coordination, and other measures of health that have meaning to patients (focused on function, wellness, and overall health status). We share the concerns CMS cites relative to the inclusion of engaging patients in the development of measures, and appreciate CMS description of "recent best practices identified for patient/caregiver engagement" in measure development. Less progress has been made in developing measures that extend beyond direct care, such as engagement of patient and family/caregivers as part of quality improvement. **Accordingly, the Collaborative encourages further development of patient and caregiver measures that are useful in integrated team-based care settings, and that include patients and families in quality improvement efforts. In addition, we encourage CMS to explore the inclusion of qualitative research to supplement our understanding of patient and family experience measures.**

3. Population Health and Prevention (p. 34)

Meeting the Triple Aim of better care, better health, and lower cost is fundamental to the Collaborative. Emerging data demonstrate that community-level engagement can promote better health, i.e. improved clinical and population health outcomes.[6] In addition to coordinating care for patients across the medical neighborhood, the goals of a high-functioning PCMH include collaborating with community and social supports to support the health and social needs of the community. PCMHs can link to non-clinical partners like community centers, faith-based organizations, schools, employers, public health agencies, YMCAs, and those, like Meals on Wheels, who provide nutrition and social support to those who are homebound. Working together, these organizations can actively promote care coordination, fitness, healthy behaviors, proper nutrition, chronic disease management, and peer support. Accordingly, the need for community level measures of population health is growing, but limited in use. **We encourage CMS to prioritize the development and implementation of these measures, using guidance from the Institute of Medicine (IOM) Vital Signs: Core Metrics for Health and Health Care Progress report, and including measures that impact population health, such as life expectancy, well-being, overweight and obesity, addictive behavior, unintended pregnancy, healthy communities, preventive services, and community engagement.**

4. Efficiency and Cost Reduction (p. 34)

An estimated 30 percent of the total US health care spend can be attributed to overuse, underuse, and misuse of health care resources.[7] Notably, and not coincidentally, most countries with more efficient and effective systems prioritize primary care through more aligned payment and workforce policies. Although the U.S. spent over 2.9 trillion dollars on health care in 2013[8], just four to seven percent of that total spend was dedicated to primary care.[9] Despite this very modest dollar outlay, primary care visits in the U.S account for more than half (55 percent) of physician office visits each year.[10]

Patients are increasingly expressing their wish to be better informed "consumers" of care, and are interested and beginning to demand more transparency about cost and quality, convenience and access, and new ways to seek care outside of traditional office visits, such as the use of telehealth, (especially for those in rural or underserved communities) and mobile technologies (that appeal to those who are interested in self-management and/or wellness). Transparency and convenience are increasingly important for Medicare beneficiaries with chronic conditions who must balance factors of cost (out-of-pocket), quality, and convenience of services. Strategies like the Choosing Wisely Campaign from the American Board of Internal Medicine – and widely embraced across various health professions organizations and some consumer organizations -- can help primary care practices and consumers identify areas of potential overuse of health care services. However, we are also concerned about measures of underuse and/or misuse of health care services. We must be mindful to not repeat the mistakes of the 1990s managed care capitation models which gave rise to concerns about limitation of care, especially for low income, vulnerable populations.

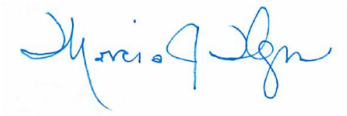
Accordingly, we support CMS proposal to include efficiency and cost reduction as a quality domain in additional to the five quality domains identified in MACRA (clinical care, safety, care coordination, patient and caregiver experience, and population health) (p. 31) but encourage the development of "balancing measures" to ensure the underuse of needed health services is not an unintended consequence of MACRA implementation.

5. Applicability of Measures Across Healthcare Settings (p. 36)

Few health professionals working in isolation can meet the comprehensive needs of their community without a trusted team that partners with their patient and family/caregivers. This is especially the case for those with chronic conditions who often suffer from depression or other behavioral health issues. A team-based interprofessional workforce is critical to ensuring timely appropriate access to care and is a hallmark of the PCMH and is becoming a priority for efficient and effective health care delivery. However, performance measures are typically measured at an individual clinical level, physician group, or health plan level, which does not allow for an assessment of the contribution of each team member, and instead undermines a culture of team-based interprofessional care. Team-based care consists of several elements. One aspect is incorporating members with different skills into the medical home, such as health coaches, pharmacists, and behavioral health professionals. Another component is supporting every team member to be able to practice at the top of their license and skills. A final element is promoting teamwork, so that all members understand each other's roles and responsibilities and have regular communication regarding patient care goals with mutual accountability toward a shared care plan developed in partnership with the patient and their family or caregiver. **We encourage CMS to consider the development of measures that assess the functionality of teams, and the development and/or adaptation of current measures that can be used in team -based care settings and encourage competencies of team-based care.**

We appreciate this opportunity to offer our comments on CMS draft Quality Measurement Development Plan and offer our assistance as a multi-stakeholder group interested in generating creative solutions for use of measures across multiple payers and delivery systems, in order to promote better care, better health, and lower cost. As the Centers for Medicare and Medicaid Services (CMS) defines PCMH and supports it through value-based purchasing arrangements as required by MACRA, the medical home will be scaled and spread. Accordingly, the Collaborative believes that is critical to unify patients/consumers (including families/caregivers), health care providers, and payers around the value of advanced primary care and PCMH. We would appreciate the opportunity to share the Collaborative's perspective on important measures that best define the PCMH, consistent with the goals and objectives of the CMS Quality Measurement Development Plan.

Sincerely,



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[1] The Medicare Access and CHIP Reauthorization Act of 2015. Public Law No: 114-10

[2] American Academy of Family Physicians. (2015). Data brief: 2015 value-based payment study. Retrieved from: http://www.aafp.org/dam/AAFP/documents/news/Data%20Brief- 2015_Value%20Based_Payment.pdf

[3] Takach, M., Townley, C., Yalowich, R., Kinsler, S. (2015). Making multipayer reform work: what can be learned from medical home initiatives. Health Affairs. 34(10. doi: 10.1377/hlthaff.2014.1083

[4] Taylor et al. (2015). Evaluation of the Comprehensive Primary Care Initiative: First Annual Report. Mathematica Policy Research. Retrieved from: http://innovation.cms.gov/Files/reports/CPCI-EvalRpt1.pdf

[5] Dulsky Watkins, L. (2014). Aligning payers and practices to transform primary care: a report from the Multi-state Collaborative. The Milbank Memorial Fund.

[6] Vojta, D., Koehler, T.B., Longjohn, M., Lever, J.A., Caputo, N.F. (2013). A coordinated national model for Diabetes prevention. American Journal of Preventive Medicine. 44(4). Doi: http://dx.doi.org/10.1016/j.amepre.2012.12.018

[7] Berwick, D.M., & Hackbarth, A.D. (2012). Eliminating waste in US health care. *JAMA, 307(14),* 1513-6. doi: 10.1001/jama.2012.362

[8] Centers for Medicare & Medicaid Services. (2014). *NHE Projections 2013 – 2023 – Tables*. Retrieved from http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html

[9] Goroll, A.H., Berenson, R.A., Schoenbaum, S.C., & Gardner, L.B. (2007). Fundamental reform of payment for adult primary care: comprehensive payment for comprehensive care. Journal of General Internal Medicine, 22(3), 410–415. doi: 10.1007/ s11606-006-0083-2

[9] Phillips, R. L., Jr., & Bazemore, A.W. (2010). Primary care and why it matters for U.S. health system reform. Health Affairs, 29(5), 806-10. doi: 10.1377/hlthaff.2010.0020.

[9] Health Care Cost Institute. (2014). 2013 Health care cost and utilization report appendix, table A1: expenditures per capita by service category and region (2011-2013). Retrieved from http://www.healthcostinstitute.org/files/2013%20HCCUR%20 10-28-14.pdf

[10] U.S. Centers for Disease Control and Prevention. (2010). *National ambulatory medical care survey: 2010 summary tables, table 1*. Retrieved from http://www.cdc.gov/nchs/data/ahcd/namcs_summary/2010_namcs_web_tables.pdf