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

Submitted via email to: MACRA-MDP@hsag.com

Dear Mr. Slavitt:

The Center for Consumer Engagement in Health Innovation at Community Catalyst respectfully submits the following comments to the Draft CMS Quality Measure Development Plan (MDP).

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1997, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. The Center for Consumer Engagement in Health Innovation is a hub devoted to teaching, learning and sharing knowledge to bring the consumer experience to the forefront of health. The Center works directly with consumer advocates to increase the skills and power they have to establish an effective voice at all levels of the health care system. We collaborate with innovative health plans, hospitals and providers to incorporate the consumer experience into the design of their systems of care. We work with state and federal policymakers to spur change that makes the health system more responsive to consumers.

CMS' proposed changes to physician payment are of great interest to consumers because payment structures and quality measurement directly shape how care is delivered. Moreover, because of the influence that Medicare has on the health care system as a whole, these changes affect not only Medicare beneficiaries, but all consumers in the United States.

Community Catalyst therefore appreciates the opportunity to provide comments to CMS on the MDP. We focus our comments on five key areas: patient engagement in measure selection and development; importance of quality measurement in protecting against underutilization; impact on providers serving socioeconomically disadvantaged populations; inclusion of patient-centered measures; flexibility to ensure that quality measures reflect the goals, preferences, and needs of patients; and consumer engagement in the presentation of quality measurement results.

Patient engagement in measure selection and development of measures

We appreciate the inclusion of consumer voice into the development of measures, including in the General Principles (p. 19). We agree with CMS that consumers must have input in defining the measures that are most meaningful. We would ask that CMS pay particular attention to ensuring that low-income and vulnerable populations have a voice in the measure development and selection processes. We note that these populations are most at risk in the shift to value-based payments, and it is critically important to ensure that the way that quality is incentivized and measured takes into account the goals, needs and preferences of the populations served. We note that to ensure effective, meaningful participation, adequate support must be provided in terms of training and direct resource support.

When it comes to “multi-payer applicability of measures” (p. 23), we recommend that CMS ensure that there is robust consumer engagement in each of the cited stakeholder processes. We understand that the stakeholder groups specified by CMS for input include the Measure Applications Partnership (MAP), the Core Quality Measures Collaborative, and the Health Care Payment Learning and Action Network (HCPLAN). Consumers, while represented in some of these forums, remain a small voice among many technical experts. We encourage CMS to promote more robust consumer representation at these tables as well as proactively reach out to consumer groups to solicit their input beyond these official forums.

Role of quality measurement in protecting consumers against underutilization

With respect to quality domains and priorities, one area that CMS has singled out is efficiency and cost reduction, with an emphasis on overuse. We recognize the significant overuse incentives that exist within the fee-for-service system and agree that steps should be taken to address this issue. At the same time, it is the expansion of risk-based Alternative Payment Models (APMs) that is likely to have the greatest impact on overuse. In the context of this shift, it becomes critically important to address the potential for underuse. CMS has raised the potential for underuse but mainly as an unintended byproduct of quality measurement itself. We believe that the potential for underuse is a characteristic of capitated and other payment models with two-sided risk. Consequently, quality measures that apply to APMs must place greater emphasis on underuse, even while measures in the fee-for-service system target overuse. (We note here that this is an important area where comparability across measures for the Merit-Based Incentive Payment System (MIPS) and for APMs should not be interpreted to preclude use of measures that are most appropriate to guard against the potential adverse effects that adhere to that specific payment approach).

We stress that quality measurement alone is not an adequate tool to prevent underuse and ensure that APMs do not meet cost targets at the expense of vulnerable beneficiaries. Robust engagement of beneficiaries in helping to shape the policies and priorities of integrated delivery systems, due process rights, transparency and appropriate risk are also essential.

Impact on providers serving socioeconomically disadvantaged populations

We believe that addressing health disparities should be a core goal of payment reform initiatives. We support the inclusion of several technical principles (p. 20) that could impact

the care of low-income and vulnerable populations. In particular, we draw your attention to #7, the inclusion of measure stratification across different patient demographic characteristics such as race, ethnicity, primary language, age, disability status, gender identity and sexual orientation, to support the ability to monitor disparities and unintended consequences. We recognize that all communities must have the opportunity to have high quality care, but that providers in some communities may need more resources in order to be able to meet the same targets. We believe that stratification of results will allow for disparities to be identified and addressed. We further believe that there should be adequate payment to providers, based on the characteristics of the community they serve, in order to meet quality goals.

Inclusion of patient-centered measures

We appreciate CMS' emphasis on the domains of Care Coordination, Patient and Caregiver Experience and Population Health and Prevention.

Care coordination is essential, particularly for those consumers who have multiple chronic conditions and need access to an array of health care providers. For low-income consumers facing these challenges, navigating the health care system is extremely difficult, thus requiring CMS's emphasis on timely and appropriate communication with them and their health care team. The role of care coordinators is essential, but far too often lacking as our recent survey of health plans operating in the Financial Alignment Demonstration found.¹

In many programs, patient experience of care is one of the few measures used to evaluate elements of care that patients and family caregivers identify as most important to improving their health outcomes and to their care experience. We strongly support the improvement, refinement and expansion of using patient and caregiver experience to assess care. Gauging a patient's experience of care is especially important for those who have multiple conditions and for whom condition-specific quality measures cannot provide an adequate picture of the total quality of care received. Moreover, patient experience has the added benefit of addressing cross-cutting issues that apply across specialties. Family caregiver experience data are also particularly helpful in assessing experience of care and in providing insights into areas patients may be reticent to discuss. We note that in order to measure the true quality of services that a patient receives, measures must fully capture the patient and their family (if appropriate) experience with that care. Given the limitations of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, Community Catalyst strongly encourages CMS to include capturing qualitative data based on patient narratives.²

With regard to the population-based measures, we support CMS' focus on the Institute of Medicine's *Vital Signs* recommendations, particularly its inclusion of healthy communities and community engagement. We encourage CMS to think of consumer engagement, not just in the clinical setting, but also at the organizational level (such as governance and quality improvement) and in the policymaking level.

¹ Community Catalyst and Association of Community Affiliated Plans, [Key Consumer Provisions in the Dual Demonstrations: Findings from a Survey of ACAP Plans](#), December 2015.

² Schlesinger M, Grob R, Shaller D, Martino SC, Parker AM, Finucane ML, Cerully JL, Rybowski L. Taking Patients' Narratives about Clinicians from Anecdote to Science. *N Engl J Med* 2015; 373:675-679.

Finally, we support the use of patient-reported outcomes (PROs). PROs can be used to determine if patients benefit from treatment in ways that matter to them, to providers and to society – improved functioning, reduced pain, and improved quality of life. PROs measure a patient’s assessment of his/her physical and/or mental health using standardized survey instruments. We strongly support prioritizing these measures as part of the MDP. While these data are collected in clinical practice on a national scale in other countries, the U.S. does not yet have a systematic infrastructure for collecting and reporting PROs. However, in the U.S., using patient generated data for improving care is not new, as evidenced by the widespread use of CAHPS survey instruments. Additionally, several large health systems and others have experience collecting PROs and using the data on a broad scale. We recommend CMS build on what already has been learned in collecting information from patients, work collaboratively with those who are actively involved in furthering this work and dedicate resources to refining methods appropriate to patient-reported outcomes measures. For example, there are a variety of factors to consider in the administration and reporting of PROs, such as use of technology, incorporation into the clinical workflow, and risk-adjustment models.

Flexibility to ensure that quality measures reflect the goals, preferences, and needs of patients

Too often, quality measures used in value-based health initiatives focus on condition-specific standards. While this approach may work for beneficiaries with a single condition, it is not necessarily in the best interests of those with multiple chronic conditions. For these more vulnerable beneficiaries, complying with multiple treatment guidelines may impose an undue burden of care and may, in fact, be harmful. For example, a frail elder with frequent falls would not be well served by a focus on tight blood sugar control, and a patient with a recent hip fracture would not be a good candidate for a routine screening colonoscopy, until they are recovered.

We believe that in developing and applying measures, CMS must carefully consider exclusion and exception criteria, in order to allow patients and providers the flexibility to focus on what matters most. We recommend that CMS allow patients and clinicians to jointly determine whether a patient could be excluded from certain quality measures that are not clinically appropriate and could in fact be at odds with the individual patient’s goals and desires.

We also support the use of **patient goals-directed measures**. These measures focus on a person’s individual health goals within or across a variety of dimensions (e.g., symptoms; physical functional status, including mobility; and social and role functions) and determine how well these goals are being met.³ A goals-directed approach has many advantages:

³ Reuben D., Tinetti M. Goal-Oriented Patient Care – An Alternative Health Outcomes Paradigm, *N Engl J Med* 2012; 366:777-779; Lynn J., McKethan A., Jha A. Value-Based Payments Require Valuing What Matters to Patients, *JAMA*. 2015;314(14):1445-1446.

- It frames the patient-provider discussion in terms of individually desired rather than universally applied health states.
- It simplifies decision-making for patients with multiple conditions by focusing on outcomes that span conditions and aligns treatments toward common goals.
- It prompts patients to prioritize which health states are important to them, thus allowing them to be in control when treatment options require trade-offs.
- It allows for effective shared decision-making between patient and provider about which treatment strategies will meet the patient's goals.⁴

While patient goals-directed measures are under development,⁵ we recommend CMS consider collecting data about goal-setting. For instance, it could measure whether a provider has had a discussion with a patient about – and documented in the electronic health record – his/her goals of care. This conversation could happen as part of a comprehensive risk assessment, the development of an individualized care plan or during routine patient care.

Consumer engagement in the presentation of quality measurement results

We note the requirement in the MDP that measures should be suitable for public reporting on the CMS Physician Compare website. We believe it is important that consumers be engaged in the design of reports to ensure that information is relevant, accessible, intelligible and as consumer-friendly and consumer-focused as possible. We would urge CMS to engage with diverse groups of consumers, including people with disabilities, who have a different set of needs than older Americans on Medicare, and also conduct testing in other languages to account for Medicare beneficiaries whose first language is not English.

We appreciate the opportunity to submit these comments and will continue to follow the MACRA implementation process with great interest. We look forward to working with you to ensure that the transition to new payment structures serves to improve the health of all Americans.

Sincerely,



Ann Hwang, MD
Director, Center for Consumer Engagement in Health Innovation

⁴ Reuben & Tinetti, 2012.

⁵ [Quality Measurement to Assess the Performance of Goal Setting and Achievement in the Delivery of Medical and Long-Term Care](#), 2015