

# Consumer-Purchaser ALLIANCE

Better information. Better decisions. Better health care.

March 1, 2016

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

RE: MACRA Measure Development Plan

Dear Mr. Slavitt:

The 21 undersigned organizations are from a collaboration of leading consumer, labor, and purchaser organizations committed to improving the quality and affordability of health care through the use of performance information to inform consumer choice, payment, and quality improvement. Both collectively and individually, our organizations have actively been involved in promoting the development and use of high-value performance measures. We appreciate the opportunity to submit comments to CMS on the draft Measure Development Plan.

We commend CMS's leadership in advancing healthcare performance measures that will provide meaningful and actionable information to consumers and purchasers. Now, more than ever, we need high-value measures to understand the quality of care provided by clinicians in a rapidly changing environment. CMS has an incredible opportunity to advance measure development through funding from the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Measure Development Plan (MDP), as required by MACRA, sets the stage for how CMS will address the gaps in clinician performance measures. It provides an overall vision for systematically addressing these gaps and the challenges that impede progress toward high value measurement. We are pleased that CMS was responsive to the priorities and concerns we shared in previous comments. In particular, we commend CMS for:

- Prioritizing measures that are important to consumers and purchasers, such as clinical outcomes, patient-reported outcomes, patient experience, and appropriate use;<sup>1</sup>

---

<sup>1</sup> For brevity, we refer throughout our comments to "patient" and "care," given that many federal programs and initiatives are rooted in the medical model. To some, these terms could imply a focus on episodes of illness and exclusive dependency on professionals. Any effort to improve patient and family engagement must include the use of terminology that also resonates with the numerous consumer perspectives not adequately reflected by medical model terminology. For example, people with disabilities frequently refer to themselves as "consumers" or merely "persons" (rather than patients). Similarly, the health care

- Actively engaging patients and family caregivers in the measure development process; and
- Focusing on rapid-cycle activities to improve the efficiency of the measure development process.

In order to implement the vision laid out in the plan, CMS must find the right balance between filling the most pressing measure gaps, investing in infrastructure for better data collection, improving measurement development processes, and ensuring measures evolve appropriately to support the transition to alternative payment models. We believe the draft MDP lays a strong foundation for high-value measure priorities and patient/family caregiver engagement in measure development, and we offer additional comments in the Appendix to help further shape these areas. In addition, we recommend that the MDP go further in two important areas: the feasibility and efficiency of data collection, and clinician-level measurement. Below we offer guidance for these two areas.

### ***Feasibility and Efficiency of Data Collection***

The health system often fails to adequately coordinate care across a fragmented system of providers. Health information technology and exchange are essential for better care coordination and interconnectivity and continuity across patients and family caregivers, providers, community health resources, and public health officials. Additionally, Health IT and information exchange facilitate our ability to collect the data needed to measure quality. We encourage CMS to measure and reward the meaningful activities and outcomes that electronic health information technology and exchange enable—such as care coordination and patient engagement. This, also, will help drive effective adoption and use of health information technology (HIT) as well as better care coordination and outcomes.

For example, critical new incentives for the use of health information technology take effect in 2017 and 2018 in the Meaningful Use program, and we encourage CMS to reinforce them in its Measure Development Plan. Stage 3 requirements give patients and family caregivers the ability to contribute their own health and non-clinical data. Stage 3 also calls for including *patients'* health goals and a common clinical data set in transitions of care. CMS should also encourage inclusion of patient-reported outcomes and patient experiences of gaps in care coordination and access. Patients and families are well positioned to identify gaps in access or care coordination, based on their direct experience. These requirements will all help patients and families be more engaged in their care.

Moreover, there are cutting edge advancements in HIT that can facilitate the collection of patient-generated data, such as wearable technology and remote-monitoring technology. Rather than waiting for a more developed marketplace, CMS should start exploring how this technology can improve the feasibility of data collection now.

Finally, we encourage CMS to be mindful of the effort and time required of patients and family caregivers to provide this data. HIT and the exchange of information creates opportunities to streamline and share the data among providers, maximizing the value of each instance a patient provides data. Enhancing and decreasing the number of questions

---

community uses the terminology “caregivers” and “care plans,” while the independent living movement may refer to “peer support” and “integrated person-centered planning.”

on standardized surveys of patient experience would also reduce the burden on patients and family caregivers.

### ***Individual Clinician Measurement***

As new models of care require providers to work collaboratively in providing high quality, efficient care, measurement science needs to evolve to address this dynamic. However, the importance of the most appropriately granular level of results should not be minimized. Within an ACO or group, there is performance variation among clinicians. Such variation calls out the need for CMS to hold individual clinicians within a group or system accountable for the quality and cost of care.

Furthermore, it is generally individual clinicians who determine diagnoses; order tests, medications, and other treatments; perform procedures; and refer to specialists and subspecialists. These decisions are key determinants of cost and outcomes. Measuring the performance of individual clinicians—particularly if this performance is benchmarked to peer performance when given to providers as feedback—is likely to lead to more rapid improvement than if measurement is only at the group level. Moreover, consumers need and want information about individual clinician performance, especially measures of patient experience and patient-reported outcomes, in order to make an informed choice on which primary care provider or specialist can best meet their needs.

Often, providers with low sample size are reported as “average” or not reported at all. This information may be misleading and does not meet consumer and purchaser needs. Instead, statistical techniques should be investigated that can yield valid and meaningful information at the clinician level even when numbers are small. Such techniques might include use of composites or combination of group and individual provider results. Measures from patient-provided information or narrative should also be considered. In regards to cost measures, outlier trimming and patient attribution rules (such as those by the Medicare Shared Savings Program) can substantially mitigate concerns about invalid comparison at a more granular level.

The years of experience CMS has in measure development has positioned it well to meet the challenge of developing a plan that addresses the imperative for filling the gaps in high-value clinician performance measures. We are pleased to see CMS seize this challenge as an opportunity to comprehensively address the often neglected needs of those who receive and pay for care. We look forward to assisting you in whatever way we can to ensure implementation of the final Measure Development Plan. If you have any questions about these recommendations, please contact Bill Kramer ([wkramer@pbgh.org](mailto:wkramer@pbgh.org)) or Debra Ness ([dln@nationalpartnership.org](mailto:dln@nationalpartnership.org)), co-Chairs of the Consumer-Purchaser Alliance.

Sincerely,

The Alliance  
American Association on Health and Disability  
Caregiver Action Network  
Center for Patient Partnerships  
Consumers’ CHECKBOOK/Center for the Study of Services  
The Empowered Patient Coalition

Health Care Incentives Improvement Institute  
Health Policy Corporation of Iowa  
Iowa Health Buyer's Alliance  
Maine Health Management Coalition  
Medicare Rights Center  
Memphis Business Group on Health  
MidAtlantic Business Group on Health  
Mothers Against Medical Error  
National Coalition for Cancer Survivorship  
National Partnership for Women & Families  
Northeast Business Group on Health  
Pacific Business Group on Health  
PULSE of America  
St. Louis Area Business Health Coalition  
Wyoming Business Coalition on Health

## **APPENDIX**

### ***Patient-reported outcomes measures***

Patient-reported outcomes (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. Evidence shows there is significant variation in these outcomes, indicating an opportunity for improvement. We strongly support prioritizing these measures as part of the Measure Development Plan.

While these data are collected in clinical practice on a national scale in other countries, particularly the UK, the US does not yet have a systematic infrastructure for collecting and reporting PROs. However, in the US, 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 (PROMs). For example, there are a variety of factors to consider in the administration and reporting of PROMs, such as use of technology, incorporation into the clinical workflow, and risk-adjustment models. Additionally, we would like to see the aggressive use of rapid cycle development processes to integrate lessons learned and best practices. As we have said in the past, we want to underscore that Clinical Practice Improvement Activities can serve as a vehicle for getting more providers to participate in the use of PROMs and developing best practices.

### ***Patient experience measures***

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 crosscutting issues that apply across specialties. Family caregiver experience data is also particularly helpful in assessing experience of care and in providing insights into areas patients may be reticent to discuss.

We support the use of an electronic short form patient experience survey to lessen survey expense and reduce respondent burden, thereby enabling measurement of patient experience at the individual physician level. For example, a recent pilot program by the

Pacific Business Group on Health and Massachusetts Health Quality Partners tested an electronic short form survey with promising results.<sup>2</sup>

### ***Patient engagement measures***

When patients are informed and effective managers of their health, not only do patient experience and clinical outcomes improve, but also health care costs are often lower. Engagement and “activation” become particularly important for patients with chronic conditions because patients can play an important role in their ongoing care and functioning. We encourage CMS to explore how patient engagement in the care they seek and/or receive can be incorporated into performance measurement.

Importantly, though, this is only a piece of the potential value of patient engagement. We also ask CMS to think of patient engagement as a broader concept that encompasses more than direct care, and consider how it contributes globally to patient-centered care. Patients can be engaged in many ways, including:

- 1) the organizational-level, such as governance and quality improvement;
- 2) the policy making-level, such as priorities for public funds; and
- 3) the community-level, such as accessing community resources.

Moreover, we believe moving beyond patient engagement to meaningful patient partnership is essential. We recognize these nascent areas lend themselves to exploratory work. We recommend CMS also use the Clinical Practice Improvement Activities to support measure development in patient engagement.

### ***Patient and caregiver engagement in measure development***

We are pleased to see the MDP focus on engagement of patients, family caregivers, and consumer advocates in quality measure development. We appreciate that CMS is carefully considering how best to partner with patients and families and consumer advocates in this important work, and we generally agree with the strategic approach as laid out in the MDP. Partnering with patients and families and consumer advocates in meaningful ways and as early as possible in the measure development process, including in the prioritization and re-evaluation of measures, will ensure that their unique insights and perspectives bring value to the process.

Further, we encourage using language that focuses on partnerships with patients and families, in contrast to language suggesting patients’ input is at odds other stakeholders or with the evidence base. We also request that CMS clarify that true engagement of patients and families, when viewed as a partnership, goes beyond asking them to share their “personal stories” – true engagement means seeking their unique perspectives and expertise, and supporting their active participation throughout the measure development process.

---

<sup>2</sup> Massachusetts Health Quality Partners & California Healthcare Performance Information System. (2015, October). *Short Form Patient Experience Survey- Research Findings*. <http://www.nrhi.org/uploads/research-findings-patient-experience.pdf>

Below, we offer suggestions to the language to strengthen the principles laid out on page 19:

- General Principle #4 –We suggest adjusting the language to encourage measure developers to seek patient/caregiver input *throughout* the measure development process.
- General Principle #8 – Important that patients/caregivers are seen as partners and measures *are equally* meaningful to patients/caregivers, providers, and the general public.
- General Principle #11 –Suggested new language for this principle is: Partner with patients and family caregivers and their advocates to ensure a focus on what is best for patients and family caregivers for each decision made during the development life cycle.

We also encourage CMS to think more broadly about the avenues in which patients can contribute and provide input to the measure development process. As it stands, most of the focus is in serving as a member of a Technical Advisory Panel or committee. Furthermore, these types of commitments are often at least one year. Some patients, caregivers and advocates are able to commit the time to participate in such a process. However, CMS should also consider a broader range of opportunities for patients and caregivers to contribute to the measure development process, including more discrete opportunities. For example, CMS could engage patients and caregivers on the prioritization of measure concepts through the Delphi method or key informant interviews.

There may be lessons or best practices from outside the measure development arena that can be used to inform the involvement of patients and caregivers. For example, the toolkit to support clinical practice guidelines developers in involving patients and the public in the entire cycle offers many parallels to the performance measure development cycle.<sup>3</sup>

Finally, we note an additional barrier not included in the Measure Development Plan. Some patient engagement efforts have been interpreted as subject to the Paperwork Reduction Act (PRA) and its restrictions. We believe this is too narrow of an interpretation. While we support the intent of the PRA to protect individuals, we do not believe the spirit of the law intended to hamper patient engagement in quality improvement efforts.

### ***Other comments***

Below are some additional comments on a few other areas in the draft MDP:

- We support stronger mechanisms to facilitate sharing of information and coordination of efforts among measure developers. Current measure development efforts often create siloes in ways that lead to the inefficient use of resources. For example, a surgical quality measure such as a patient's report of pain is appropriate at both the surgeon and hospital level, yet these measures are bifurcated and developed separately.
- Since MACRA requires non-NQF endorsed measures to submit to a peer reviewed journal, we recommend that CMS incorporate 'submission of measure manuscript'

---

<sup>3</sup> See Guidelines International Network's Patient and Public Involvement Work Group (G-I-N PUBLIC) at <http://www.g-i-n.net/working-groups/gin-public/toolkit>.

as a standard deliverable for their funding contracts with measure developers. This ensures that the requirement is systematically met.

- We strongly recommend CMS invest in exploration and foundation of how to measure diagnostic skills. This is an area that has received much less attention to date and studies have shown that diagnostic errors are common.<sup>4</sup>

---

<sup>4</sup> Institute of Medicine. *Improving Diagnosis in Health Care*. Washington, DC: The National Academies Press; 2015.