Consumer-Purchaser
DISCLOSURE
PROJECT Improving Health Care Quality through Public Reporting of Performance

August 31, 2007

Herb Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Ave., NW
Washington, DC 20201

File Code: CMS-1385-P (Proposed Revisions to Payment Policies Under the Physician Fee Schedule)

RE: TRHCA —SECTION 101(b): PQRI

Dear Mr. Kuhn:

The 31 undersigned organizations representing consumer, labor, and purchaser interests believe strongly that the system of payment for services provided or controlled by physicians, for both Medicare and commercial payers, is in need of a major overhaul. Physicians are central to the delivery of health care and many seek to provide the best care possible. Unfortunately, rather than promoting better quality, coordination, greater efficiency and more effective delivery of care, most payments reward quantity, errors, rework and unnecessary care. Medicare can, and should, lead the way in reforming these dysfunctional payment policies.

Overall, we believe that the path that you are proceeding down under the Physician Quality Reporting Initiative (PQRI) must be one part of wide-ranging efforts to reform how providers are paid and held accountable. The PQRI program is a step in the right direction to aligning payment with performance, and in particular we support the following elements:

- We agree that the intention should be to use measures that have been endorsed by the National Quality Forum. At the same time, we are deeply concerned that there remain few measures that can be easily collected and that would provide physicians with a clear picture of their practice. Because of this, we support – as an interim process – allowing for the use of AQA approved measures in circumstances where no NQF-endorsed measures exist.

- We agree with and affirm the CMS interpretation that endorsing organizations are not limited to considering measures submitted by physician specialty organizations. While some specialty societies have risen to the challenge of developing robust measures – in too many cases the measures developed are weak and do not provide consumers,

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purchasers or physicians themselves with anything close to a fair picture of performance. Additionally, it can be argued that single physician specialty submissions may result in confusion and redundancy since it is not uncommon for multiple specialties to provide the same procedures or care.

- We support CMS' having participation in the STS registry meet the incentive requirements – but believe that, as with all PQRI measures, the results be made public.

- We agree that CMS should explore additional data submission methods, including the submission of data from EHRs and the generation of performance results from administrative data that requires no submission or additional coding beyond the normal claims submission done by physicians.

While we agree with some core components of the program, we view it as an initial step and significantly more needs to be done to meet the goal of aligning payment with performance. What follows are suggestions we urge you to consider to improve the PQRI program:

The Federal Government must support the development and endorsement of a robust set of physician (and other provider) performance measures. There needs to be a greater focus on measures that assess high levels of performance rather than adherence to minimum standards of competence. Additionally, measures need to address all of the IOM's six aims (safe, timely, effective, efficient, equitable, patient-centered), and in particular there is a need for physician-specific measures on patient-centeredness (including family-centered care), equity/disparities, and episodes of care based quality and efficiency. While we affirm the use of both structural and process measures, there is currently too much reliance on process measures that have not been directly linked to outcomes. Outcome measures are desperately needed and we are concerned that over-reliance on process measures that are not linked to outcomes and reflect only minimum standards of competence will "clog" the system and divert from resources that should be allocated to measures that are far more meaningful to consumers and purchasers.

Additionally, measures should be prioritized for development and/or use that do not require additional coding and that can be generated from existing administrative data (including claims and Medicare Part D/pharmacy data). We must move forward with the administrative data now so that we can meet the needs of employees, patients, and other consumers who need information to make informed decisions. With administrative data (that does not rely on voluntary coding), Medicare can evaluate the performance of each health care provider that bills Medicare, using nationally-endorsed, scientifically-valid, risk-adjusted, and regularly-updated measures. We also must continue to proactively pursue the submission of data via other electronic means, including electronic health records.

<u>Recommended Actions</u>

- HHS or CMS should provide substantial and ongoing funding to support development of consumer-relevant measures that fill existing gaps (especially episode based quality and efficiency, patient-centered/continuum of care, and equity). Developing measures is a public good that requires significant financing from the public sector. Because of the lack of well-specified and endorsed measures that meet consumers' and purchasers' needs, the federal government should specifically support the rapid development of measures that are:
  - Reasonably scientifically acceptable. Consumers and purchasers want measures to be scientifically sound and evidence-based, but do not want the pursuit of perfection to delay the availability of good and useful information.

  - Feasible to implement. Rapid reporting necessitates measures are constructed and specified so that the data needed are currently available or can be collected with limited reporting burden.
  - Relevant to consumers and purchasers. The needs of consumers and purchasers for important and actionable information must drive the development of measures.
  - Reflect the continuum of care/care coordination from a patient's perspective. Measures should address the extent to which comprehensive, patient-centered care is delivered, often by multiple providers and across multiple settings.
- HHS or CMS should provide core ongoing operating support for the National Quality Forum (NQF) to ensure an ongoing, independent consensus process reviews, endorses, and updates measures to enable the availability of comparative information and the reduction of provider reporting burden.
- CMS should strongly consider and explore use of specialty boards' Maintenance of Certification (MOC) programs as a means to meet PQRI where the underlying clinical and patient experience performance information that will be provided meets or exceeds the requirements as both programs evolve
- CMS should produce reports based on existing administrative data (that does not require voluntary coding) for all physicians that bill Medicare.
- CMS should strengthen the link between the PQRI and Better Quality Information (BQI) for Medicare Beneficiaries by allowing performance measures collected by BQIs that are either parallel or are more robust than those being required under the PQRI to be used for providing credit (e.g., financial reward) consistent with what would have occurred had they submitted their measures through PQRI processes.
- CMS should consider using NCQA's Physician Practice Connections and Back Pain Recognition Programs as measures in 2008, provided they meet other requirements of the PQRI, such as NQF or AQA endorsement.
- CMS should launch (or at least pilot) Clinician/Group CAHPS and make patient experience a core element of any reward system. In California, over 3,000 primary and specialty care physicians are being assessed based on patient-level standardized surveys. Massachusetts has also demonstrated in the commercial and Medicaid populations that it is possible to obtain reliable and valid measures of patient experience on primary care physicians.

CMS should ensure that measures are reported publicly to foster improvement, accountability and consumers' ability to make better informed decisions. The PQRI results must be made public. Medicare should provide the public with the information on the aspects of provider performance described above. Doing so will: 1) allow consumers to make informed decisions about their health care; 2) support insurers and purchasers in making value-based contracting decisions and using differential payments as incentives; and 3) spur providers to increase the pace of their improvement efforts.

<u>Recommended Actions</u>

- CMS should develop and implement a strategy for making public the results of the PQRI reporting data, including all the components of what are considered structural or composite measures.
- CMS should immediately make available physician-identifiable Medicare claims data (fully protecting patient privacy), to allow for better quality and efficiency performance reporting.

CMS should differentially pay providers who deliver higher quality, evidence-based care more efficiently and not just "pay for reporting". Incentives should support the evolution of the health care system into one that delivers appropriate, high-quality, efficient, equitable, and patient-centered care. In addition to moving from pay for reporting to pay for performance, changes need to foster a reimbursement system that:

- Encourages care coordination and supports the integration and delivery of services for those with chronic illnesses, such as a medical home.
- Drives rapid re-engineering of care delivery, such as those that are IT-enabled.
- Reduces health care disparities and encourages the provision of quality care for at-risk populations.
- Supports the inclusion of improving physician performance as a part of the measurement process, such as through medical specialty board's Maintenance of Certification programs, medical home initiatives, and Better Quality Information pilots.

One way that even the current payment reforms could drive toward a health care system that accomplishes the above goals is to have a disproportionate share of incentives made available for care delivery that promotes these goals (rather than having all types of care have the same potential rewards for "better" performance).

We also concur with the Institute of Medicine's (IOM) *Rewarding Provider Performance* report that recommends that incentives should be based on a combination of improvement and meeting performance thresholds. As Medicare moves to institutionalize performance-based payment, it should consider how to use baseline thresholds of performance and the potential of relative comparisons to encourage and foster action by all physicians to make improvements appropriate to their current level of performance. We also support the IOM's recommendation to initially focus on efficiency, effectiveness and patient-centeredness.

Recommended Actions

- Over time, the share of payment tied to performance should be substantial. The overall proportion of CMS payments to physicians that are directly linked to performance should increase.
- CMS should set and revise the appropriate level using the information that continues to develop from its implementation of performance-based payments for eligible professionals, hospitals, demonstration projects, and from private sector efforts.
- We also strongly support performance incentives being budget neutral. Providing additional funding to finance performance incentives is an unrealistic option given the current economic and cost pressures faced by CMS.

CMS should increase the number of measures required for reporting and provide more guidance on how measures are selected. CMS should expand the number of required measures and be more directive in the criteria that providers use for the selection of measures to be reported. Instead of allowing "self-selection of 3 measures", PQRI should include as many measures as possible that can be generated from administrative data without new and additional coding for the eligible provider.

Performance reports should be produced on all physicians for whom this is possible based on existing administrative and pharmacy data (allowing for "opt-out" rather than "opt-in"). If this is not possible nationally, it should be done in those six geographic areas for which Better Quality Information pilots can generate performance measures.

Recommended Actions

- CMS should increase the number of measures required for reporting.
- CMS should develop guidelines for the selection of measures so those that are chosen are most relevant to the provider's population and reflect the most robust measures available, such as requiring a minimum number of outcomes measures.

Thank you for the opportunity to comment on the Physician Quality Reporting Initiative and your leadership in this important area. If you have any questions, please contact either of the Disclosure Project's co-chairs, Peter Lee, CEO of the Pacific Business Group on Health, or Debra Ness, President of the National Partnership for Women & Families.

Sincerely,

AARP
American Hospice Foundation
Business Health Care Group
Center for Medical Consumers
Childbirth Connection
Consumers Union
Dallas-Fort Worth Business Group on Health
Employer Health Care Alliance
Employer Health Care Alliance Cooperative
Employers' Health Coalition
Florida Health Care Coalition
Fond du Lac Businesses on Health
General Electric
General Motors
Health Policy Corporation of Iowa
HR Policy Association
Iowa Health Buyers Alliance
The Leapfrog Group
Midwest Business Group on Health
National Business Coalition on Health
National Consumers League
National Family Caregivers Association
National Partnership for Women & Families
National Retail Federation
New Jersey Health Care Quality Initiative
New York Business Group on Health
Labor/Management Health Care Coalition, Upper Midwest
Pacific Business Group on Health
Piedmont Health Coalition, Inc.
St. Louis Area Business Health Coalition
Wisconsin Purchasers for Healthcare Quality