

Consumer-Purchaser ALLIANCE

Better information. Better decisions. Better health care.

September 2, 2014

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore MD, 21244

RE: CMS 1612-P; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Medicare Part B for CY 2015

Dear Ms. Tavenner:

The 25 undersigned organizations are part of a collaboration of leading consumer, labor, and employer organizations committed to improving quality and affordability of health care through the use of performance information to guide consumer choice, payment, and quality improvement. We appreciate the opportunity to comment on the Payment Policies under the Physician Fee Schedule (PFS) and other Revisions to Part B for CY 2015 Proposed Rule.

Payment and reporting programs such as the Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (VM), and the Medicare Shared Savings Program are inextricably tied to ongoing efforts to transform the health care delivery system to meet the National Quality Strategy goals of better outcomes, improved individual experiences of care, and reduced costs. We, therefore, greatly appreciate that the proposed rule reflects CMS's concerted efforts to be responsive to the needs of consumers and purchasers. In particular, we support the removal of process measures from PQRS that do not meaningfully contribute to improved patient outcomes and the removal of measures where the performance rates are close to 100%.

We are pleased with CMS's proposals to expand data collection on practice expenses and develop validation models for Practice Expense Relative Value Units and increase transparency in its process for receiving information on new and revised codes. We are encouraged by CMS' efforts to improve care coordination by promoting complex care management, but believe this improvement cannot be achieved solely with the creation of a new payment code for non face-to-face chronic care management.

In our comments, we urge CMS to continue to improve the content of Physician Compare by populating the site with clinically meaningful and patient-reported measures and we enthusiastically support publicly reporting patient experience information, especially at the individual physician level.

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We restate our opposition to the proposal to slow down the implementation of Meaningful Use. We also oppose CMS's proposal under the Medicare shared Savings Program to adjust the quality performance benchmarks for "topped out" measures.

We recognize that CMS is working within an inherently-flawed fee for service system that continues to reward the number of services rather than their value. Therefore, we commend CMS for taking steps toward improving the existing programs and hope that these steps will ultimately support new payment systems that provide resources to health care providers to improve the quality of care.

We reiterate our support for performance assessment as a tool to determine eligibility for financial and other rewards and therefore wish to reemphasize the need for CMS to address measure gaps in areas of critical importance, such as clinical and patient-reported outcomes, appropriateness, and resource use.

In the **Appendix**, we provide specific suggestions on programs in the proposed rule. If you have any questions, please contact either of the Consumer-Purchaser Alliance's co-chairs, William Kramer, Executive Director for National Health Policy for Pacific Business Group on Health or Debra Ness, President of the National Partnership for Women & Families.

Sincerely,

AARP
The Alliance
American Benefits Council
American Cancer Society Cancer Action Network
Caregiver Action Network
Center for Healthcare Decisions
Center for Medical Consumers
Consumers' CHECKBOOK/Center for the Study of Services
Dallas-Fort Worth Business Group on Health
The Empowered Patient Coalition
Group Insurance Commission, Commonwealth of Massachusetts
HealthCare 21 Business Coalition
Health Care Incentives Improvement Institute
Health Policy Corporation of Iowa
Iowa Health Buyer's Alliance
Maine Health Management Coalition
Mothers Against Medical Error
National Partnership for Women & Families
Northeast Business Group on Health
Pacific Business Group on Health
St. Louis Area Business Health Coalition
Texas Business Group on Health
UNITE Here Health
Virginia Business Coalition on Health
Wyoming Business Coalition on Health

APPENDIX

POTENTIALLY MISVALUED SERVICES

Identifying, Reviewing, and Validating the RVUs of Potentially Misvalued Services

The CY 2015 Practice Expense Relative Value Units RVUs are based entirely on the Physician Practice Information Survey (PPIS) data, which we believe utilizes an unreliable methodology. We also are concerned that this survey is conducted and paid for by the American Medical Association (AMA), which, as a physician membership organization, has a direct conflict of interest in the survey results.

In previous comments we have recommend that the PPIS be revised with a more rigorous methodology and recognize that CMS has begun gathering data independently of the AMA. CMS previously noted that it contracted with two outside entities, Urban Institute and RAND Corporation to develop validation models for RVUs and we applaud this move. We encourage CMS to explore recommendations by Urban Institute on how to overcome challenges in collecting objective time data and devote additional resources to expand this data collection with the goal of improving the accuracy of the practice and intensity of time expenses.

“Off-Campus” Hospital Departments

CMS proposes to begin collecting data on services furnished in off-campus provider-based departments beginning in 2015. CMS intends to use this data to evaluate whether practice expense methodology should be revised in response to the growing number of hospital acquisitions of physician practices.

MedPAC continues to question the appropriateness of increased Medicare payments when physician offices become hospital outpatient departments, and the Commission recommends that Medicare pay selected hospital outpatient services at physician fee schedule rates. We agree with the spirit of the MedPAC proposal and believe that **CMS should pay physicians at the same rate for the same service, regardless of the site where the service is provided**, to discourage unnecessary use of more expensive facilities. We recommend CMS reconsider revisiting its 2014 proposal to reduce payments when a Medicare physician office payment exceeds the amount paid in the outpatient hospital department or ambulatory surgical center (ASC) setting.

Valuing New, Revised and Potentially Misvalued Codes

CMS is proposing to take public comments into account before making changes in the work and MP RVUs and the direct PE inputs for new, revised and potentially misvalued services. We are supportive of the new policy to ensure that revisions of misvalued codes go through notice and comment rule-making before being adopted. We commend CMS’s efforts to increase transparency in its process for receiving information on new and revised codes and we believe that changes to payment rates for particular services should be effective only after CMS has responded to public comment.

MEDICARE TELEHEALTH SERVICES

Additions to the List of Medicare Telehealth Services

We support CMS's proposal to add four new services to the list of Medicare telehealth services for which eligible professionals may bill: psychoanalysis; family psychotherapy; prolonged evaluation and management services; and an annual wellness visit that includes a personalized prevention plan of service. For those services which CMS has declined telehealth payment coverage, we believe CMS has provided sufficient rationale to explain the exclusion of those services – some of the services are not separately payable by Medicare and others require close observation of how a patient responds to treatment.

COMPLEX CHRONIC CARE MANAGEMENT

Complex health care needs account for a high percentage of annual medical expenditures.¹ We believe that care coordination is an integral part of improving patient care and, if done effectively, can have an impact on reducing costs. Traditionally, non-face-to-face chronic care management (CCM) services are bundled into the payment for face-to-face evaluation and management (E&M) services. However, these payments have not been sufficient to cover the significant staffing and technology investments required for chronic care management. We commend CMS for moving forward with its proposal to make an additional payment for non-face-to-face chronic care management (CCM) services, beginning January 1, 2015.

With two exceptions, CMS has not changed the elements of CCM services outlined in the 2014 Medicare Physician Fee Schedule Final Rule. We support CMS's proposal to eliminate the requirement that CCM services be furnished under direct physician supervision and believe that a requirement for general supervision is sufficient. CMS is also proposing to require that a provider furnishing CCM services utilize an electronic health record (EHR) system certified by the National Coordinator for Health Information Technology (ONC). We are strongly supportive of this certified EHR requirement.

While we support CMS' efforts to improve care coordination by promoting complex care management, we do not believe CMS can achieve the goal of improving care coordination solely with the creation of a new payment code for non face-to-face chronic care management. The method of communication with the patient plays an important role in program outcomes. Although it can be more difficult and expensive to implement, in-person care management is the best intervention to generate cost savings and improve clinical outcomes.² Person-to-person encounters, including home visits, are important for effective care management. Care management performed remotely via telephone, using no in-person contact, has been unsuccessful for complex patients.³

¹ Druss BG, Marcus SC, Olfson M, et al. Comparing the national economic burden of five chronic conditions. *Health Aff (Millwood)* 2001; 20(6):233-41.

² Julie Sochalski, What Works In Chronic Care Management: The Case Of Heart Failure *Health Aff* January/February 2009 28:179-189;doi:10.1377/hlthaff.28.1.179

³ Thomas Bodenheimer, Care management of patients with complex health care needs. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2009/rwjf49853/subassets/rwjf49853_1

The new codes center on certifying that a physician practice has the capacity to perform basic care coordination activities, rather than paying for the actual coordination. The creation of new codes can serve as an interim step until more providers are participating in global payment models.

We encourage CMS to strengthen standards in the area of quality measures and patient engagement and to create operational definitions for activities that it lists in the scope of complex chronic care management services - such as the integration of new information into the care plan. The requirements proposed by CMS include the development of a plan of care, coordination with home and community based providers, and multiple methods of non-face-to-face communication. In addition, the beneficiary must have had an annual wellness visit in the preceding 12 months furnished by the same practitioner billing for complex care management. CMS has asked if there are additional meaningful elements of chronic care management and/or beneficiary protections that it should consider. Consumers and purchasers believe that these services should be patient-centered, patient driven and individualized and include features such as:

- Continuity within the care team
- At least one goal set by the patient in collaboration with the care coordinator
- Care plan agreed to by the patient
- Documented care coordination with follow up
- Care coordination for medically complex patients across medical and non-medical settings
- Strong and trusting relationship between patient and care coordinator
- Appropriate, on-going care in the community
- Support through medical illness and comorbidities (medical, psycho-behavioral and social)
- Education of patients to understand signs and symptoms of illness before a crisis
- Providing patients with self-management tools

As we have stated in previous public comments on this issue, ultimately, **we believe it is more effective to pay clinicians based on their actual delivery of high value care.** Complex care management activities should be patient-centered and designed to improve quality of life and patient experience, and to reduce hospital readmissions. CMS should continue to focus its efforts on designing and encouraging participation in payment systems such as medical homes and Accountable Care Organizations (ACOs).

We encourage CMS to continue its commitment to improve payment for, and encourage long-term investment in, care management services that incorporate adequate safeguards against stinting on care or shunning high-cost patients.

Payment of Secondary Interpretation of Images

CMS states that questions have arisen as to whether, and under what circumstances, it would be appropriate for Medicare to permit payment when physicians furnish subsequent interpretations of existing images, and whether uncertainty associated with payment for secondary interpretations inhibits physicians from seeking out, accessing, and utilizing existing images in cases where avoidance of a new study would result in savings to Medicare.

We do not have the data to inform CMS as to what circumstances it would be appropriate to allow more routine Medicare payment for a second professional component for radiology services, or whether this policy change would reduce incidences of duplicative advanced imaging studies. However, we caution CMS that it is not necessarily uncertainty associated with payment for secondary interpretations that inhibits physicians from using existing studies but rather access to the same EHR.

When follow-up care occurs in a different institutional setting, providers may not have access to the same EHR. In such cases, electronic health information exchange (HIE) could improve the quality and timeliness of information available to the follow-up provider, thereby reducing the need to order duplicative diagnostic tests.⁴

Reports of Payments or Other Transfers of Value to Covered Recipients

CMS proposes to remove the Continuing Medical Education (CME) exemption for reporting of payments to healthcare providers who serve as speakers for accredited continuing education programs. We are supportive of transparency regarding compensation paid to physician speakers and consistent reporting for compensation provided to physician speakers at all continuing education events.

PHYSICIAN COMPARE WEBSITE

Consumers and purchasers would like the Physician Compare website to be consumer-friendly and easy-to-navigate with a strong set of clinically meaningful and patient-reported measures that fairly characterize performance and distinguish among physicians on multiple dimensions of quality.

We believe that CMS has made progress toward improving the content of Physician Compare and we are pleased to see that CMS has added to Physician Compare many high value measures such as those for diabetes control, medication reconciliation, preventive care and screening for depression and cancer, as well as the cardiovascular prevention measures group in support of the Million Hearts Initiative. However, we believe that additional work must be done to make the website more meaningful to consumers.

The Affordable Care Act (ACA)⁵ mandates that the website be populated with information on patient health outcomes, functional status, care coordination and transitions, resource use, efficiency, patient experience, and patient, caregiver and family engagement. Publicly available performance information is central to value-based health care. While we appreciate the technical challenges of populating Physician Compare with performance information, CMS should work to meet the statutory requirements as quickly as possible to foster more rapid improvement, accountability and enable consumers to make informed decisions.

⁴ Vest JR, Kern LM, Silver MD, et al. J Am Med Inform Assoc July 2014 doi:10.1136/amiajnl-2014-002760 Vest JR, Kern LM, Silver MD, et al. J Am Med Inform Assoc July 2014 doi:10.1136/amiajnl-2014-002760

⁵42 USC 1395w-5 Section 10331

The Consumer-Purchaser Alliance strongly supports the continued expansion of public reporting on Physician Compare and we are encouraged by CMS's efforts to make an even broader set of quality measures available for publication on the website. Specifically, we support CMS's proposal to expand public reporting of group-level measures by making all 2015 PQRS GPRO measure sets, across group reporting mechanisms, available for public reporting in CY 2016 for groups of 2 or more eligible professionals. Additionally, we support CMS's proposal to make all measures reported by Shared Savings Program ACOs available for public reporting on Physician Compare.

Since patients must choose individual physicians for their care, it is essential that Physician Compare report measures at the individual physician level as soon as practicable. We would suggest that the initial focus of such reporting be on patient experience with primary care physicians and on clinical quality performance by specialists.

We support CMS's proposal to publicly report all statistically valid and reliable measures in Physician Compare downloadable file, regardless of whether those measures are reported (individually or as part of composites) on the Physician Compare profile pages. We encourage CMS to make the entire dataset of each individual valid measure publicly available for download.

Composites

CMS is seeking comments on its proposal to create composites using 2015 data and publishing composite scores in 2016 by grouping measures based on the PQRS GPRO measure groups, if technically feasible. CMS is proposing to analyze the component measures of each group to see if a statistically viable composite can be constructed with data reported for 2015. We strongly support the creation of composite scores and believe that these scores will provide consumers who access Physician Compare with a more concise, and understandable picture of physician quality.

We believe that composites, generally, can provide consumers with an easy to understand picture of physician quality. Consumers and purchasers are in favor of all-or-none composites, as opposed to those composites that simply average process and/or outcome rates together, but do not indicate whether a patient actually received recommended preventive care, met goals for control of a chronic condition, or experienced no adverse events/complications from treatment. Any measure included in a composite measure should significantly improve quality and value of care. Measures included in composites should go beyond basic standards of care.

We further support CMS's proposal to create composites and publish composite scores in 2016 based on 2015 data for the following PQRS measures groups: Coronary Artery Disease, Diabetes Mellitus, General Surgery, Oncology, Preventive Care, Rheumatoid Arthritis, and Total Knee Replacement.

Benchmarks

In order to provide consumers with a point of comparison, CMS also proposes to publicly report on Physician Compare benchmarks in 2016 for 2015 PQRS GPRO data (based on 2014 data) in order to give consumers the tools to most accurately interpret published quality data. CMS would use the same methodology currently used under the Shared Savings Program. Please see our comments below on Medicare Shared Savings benchmarks.

Additional Physician Compare Proposals/Discussions

CMS is seeking comments on its proposal to include specialty society measures on Physician Compare as well as whether it should link the website to specialty society websites that publish non-PQRS measures. While we are aware that there are non-PQRS measures for specialties that have been vetted and tested by the physician community, we believe that linking away from Physician Compare to alternate websites containing those measures is unnecessary. To the extent that there are good measures from specialty societies, ready for implementation, that reflect physician quality and patient outcomes, we believe that those measures should be submitted for incorporation into PQRS and inclusion on Physician Compare. CMS should focus on making Physician Compare as comprehensive and useful for consumers as possible rather than linking away from the site to additional measures.

PHYSICIAN QUALITY REPORTING SYSTEM

Since 2007, the Physician Quality Reporting System (PQRS) has been a voluntary reporting program that provides an incentive payment to eligible professionals (EPs) who satisfactorily report data on quality measures to CMS. We are pleased to see that the Physician Quality Reporting System (PQRS) program is now transitioning from these incentive payments. CMS reiterates the two percent penalty will apply in 2017 to those who do not satisfy PQRS reporting requirements in 2015. We support CMS's moving forward with the statutory requirements of the Affordable Care Act. We hope this encourages more EPs to participate in the program.

Proposed Individual Quality Measures and Those Included in Measures Groups for the PQRS to Be Available for Satisfactory Reporting Beginning in 2015

Our support, or conditional support, for the inclusion of the 28 new measures in PQRS is based on the recommendations of the Measures Application Partnership (MAP) as reflected in the 2014 MAP Pre-rulemaking Final Report.⁶ Some examples are listed below:

- **Adherence to Antipsychotic Medications for Individuals with Schizophrenia (NQF #1879):** the Measures Application Partnerships (MAP) Clinician Workgroup recommended combining this measure with Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder into a composite and incorporating this measure into Physician Compare and the VM once it receives NQF endorsement.
- **Adult Primary Rhegmatogenous Retinal Detachment Surgery Success Rate (and Reoperation Rate):** both measures address a measurement area that is not adequately represented in the program measures set.
- **ALS Patient Care Preferences:** MAP concluded that this measure is not ready for

⁶ MAP Pre-Rulemaking Report: 2014 Recommendations on Measures for More than 20 Federal Programs; January 2014

implementation, stating that care planning for patients with ALS should occur more than are once annually and that further care planning or shorter intervals of measurement are necessary.

- **Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users:** MAP conditionally supported this measure and suggested combining it with other measures of HCV screening and referral. The measure steward, however, advises that there are nuances in how the measures are defined that make combining the measures infeasible. We support inclusion of this measure even though it may not be feasible to combine it with other measures of HCV screening and referral. The CDC has noted that HCV testing is the first step toward improving outcomes because most people with HCV do not know that they are infected.
- **Average change in functional status following lumbar spine fusion surgery:** MAP recommended that this measure be paired with measures of appropriate use of spinal surgery and episode-of-care measures that begin with initial assessments of back pain.

CMS also proposes to remove 73 measures from the PQRS for 2015. Some of these measures are being removed because the measure owner/developer can no longer maintain them (e.g., the Hypertension measures group). We encourage CMS to work with measure owners, developers or other entities to explore if they are willing or able to maintain measures of high value. We support the removal of process measures that do not meaningfully contribute to improved patient outcomes and the removal of measures where the performance rates are close to 100%, suggesting no gap in care (e.g., Perioperative measures).

Measures Groups

CMS proposes to increase the minimum number of measures that may be reported in a measures group from four to six. In doing so, it will add additional measures to measures groups that previously contained fewer than six measures.

We believe that CMS should consider raising the minimum number of measures that may be reported in a measures group to nine measures, which would be consistent with the proposed reporting requirement for individual measures. CMS should also require physicians who are reporting individually, rather than as part of a group practice, to report on all measures contained in the measures group. Allowing a choice of measures permits “cherry-picking” and may distort the actual picture of a physician’s practice. It also thwarts the consumer’s ability to compare physician practices on a standard set or composite of performance measures.

Additional PQRS Comments

We remain supportive of CMS previously finalized proposal to publicly report performance data collected for the CY2014 PQRS via claims, EHR or registry from individual EPs in CY 2015 beginning with the proposed sub-set of 20 PQRS measures submitted by individual EPs. We continue to urge CMS to implement more reporting of performance at the individual physician level as quickly as feasible.

We prefer that CMS use NQF-endorsed measures in its programs. However, in certain cases, CMS may decide to use non-endorsed measures. We support the inclusion of some measures to fill measurement gaps identified by CMS; however, we recommend that those measures be submitted for NQF endorsement.

We continue to support the elimination of the claims-based reporting option in CY 2017. By CY 2017, more physicians participating in the PQRS program will have begun using alternative reporting modalities. CMS signaled its intent to move in this direction in previous rulemakings, thereby giving physicians sufficient time to begin using alternative reporting. Eliminating claims-based reporting should spur more rapid adoption and meaningful use of EHRs. It should also be seen as meeting concerns about the reliability of claims data that are often raised by the physician community.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask patients to report on and evaluate their experiences with health care. For 2017 payment adjustment, reporting the CAHPS measures is optional for groups with 2-99 EPs. However, any size group selecting this option must use a CMS-certified survey vendor to administer the CAHPS for PQRS survey on their behalf and bear this cost. We strongly encourage CMS to make public reporting on these patient experience measures mandatory for groups of all sizes.

We enthusiastically support publicly reporting patient experience information, especially for the individual physician. Consumers find information from other patients helpful and the physician is the most salient unit of analysis for them. Physician CAHPS scores vary widely among physicians within the same medical practice. Furthermore, there is a body of evidence demonstrating that improving patient experience is directly linked to improvements in health outcomes, so public reporting also promotes quality improvement.⁷

As noted, we also encourage CMS to begin collecting patient experience survey data for individual physicians. While we understand there are methodological challenges in reporting individual-level information, we urge CMS to address these issues without delay. We believe it is feasible to provide beneficiaries with patient experience information at the individual physician level, as this has been demonstrated to be feasible in the private sector. Alternatives to the more costly, traditional paper-based survey method that take advantage of electronic media that are becoming increasingly accessible to the public should be further investigated to determine if this mode yields valid results.

We further recommend that CMS explore ways to begin collecting CG-CAHPS data from a mixture of Medicare and commercial patients to encourage public-private performance accountability alignment.

CMS also recognizes the importance of the Consumer Assessment of Healthcare Providers Surgical Care Survey (S-CAHPS) and wishes to allow for reporting of S-CAHPS in the PQRS. However, CMS does not feel it is technically feasible at this time due to the cost and time it would take for CMS to find vendors to collect S-CAHPS data. We support the collection of S-CAHPS at both the

⁷ "Health Policy Brief: Patient Engagement," *Health Affairs*, February 14, 2013

individual surgeon level and surgical practice level, as CG-CAHPS is not equally meaningful to surgeons in a multi-specialty group. CMS specifically notes that it would allow and encourage the reporting of the Consumer Assessment of Healthcare Providers Surgical Care Survey through a QCDR – we are supportive of this reporting method but also encourage CMS to begin identifying certified vendors to collect S-CAHPS data as soon as possible. We suggest starting with vendors that are CMS-certified for other CAHPS products.

Qualified Clinical Data Registries (QCDRs) requirements for 2017

CMS clarifies that for purposes of satisfactory participation, it allows QCDRs to report on any measure provided that it meets the measure parameters. CMS is proposing to maintain the parameters that were finalized last year with some modifications.

We support CMS proposal that a QCDR must possess at least 3 outcomes measures to align with the newly proposed reporting requirements or at least 2 outcome measures and at least 1 resource use measure, patient experience of care measure, or efficiency/appropriate use measure.

We believe that registry-based measures can be important tools for research, quality improvement and EP accountability by using the measures for public reporting and payment programs. We support CMS' requirement that measure specification information be disclosed by the QCDR so that consumers and purchasers can evaluate the differences in these measures and those included in PQRS.

CMS is requiring that QCDR must publicly report the title and description of the measures that it reports for purposes of the PQRS, as well as the performance results for each measure. We support this requirement and believe that the measure specification information should be publicly reported as well. We further support the requirement that this data must be available on a continuous basis and be continuously updated as the measures undergo changes in measure title and description, as well as when new performance results are calculated.

CMS is deferring to a QCDR in terms of method used to publicly report this data (e.g., it would be sufficient for a QCDR to publicly report performance rates of EPs through board or specialty websites, performance or feedback reports, listserv dashboards or announcements, or in another manner). We urge CMS to allow a QCDR to meet this requirement only if the measures data were also posted on Physician Compare.

CMS is also deferring to the QCDR to determine whether to report performance results at the individual level or to aggregate the results for certain sets of EPs who are in the same practice together (but not registered as a group practice for PQRS). CMS should require that information on performance results at the individual level be made publicly available, so long as results are valid and reliable.

Electronic Health Record (EHR) Incentive Program

The Meaningful Use and EHR Incentive Programs are foundational to ensuring that we have the health information technology infrastructure to meet the needs of health reform. We acknowledge the rationale behind CMS' and the Office of the National Coordinator for Health Information

Technology's (ONC) proposal to adjust the program timeline. Nonetheless, as previously stated in our comments to CMS, consumers and purchasers oppose the proposal to slow down the implementation of Meaningful Use.⁸

CMS is proposing that, beginning in CY 2015, EPs would *not* be required to ensure that their CEHRT products are recertified to the most recent version of the electronic specifications for the CQMs. We do not support this proposal. If the proposed changes were to go into effect, providers and hospitals experiencing difficulties in obtaining 2014 Edition Certified EHR Technology (CEHRT) would be allowed to use 2011 Edition CEHRT. Because 2011 Edition technology was only built to support Stage 1, any providers or hospitals using 2011 Edition technology in 2014 will not be able to perform critical Stage 2 functions such as secure messaging between patients and providers; offering patients the ability to view, download, and transmit their own health information; and improving care transitions with a summary of care record for transitions and referrals. Consumers and purchasers should not have to wait to realize many of the benefits of health IT, particularly the patient engagement and interoperability criteria finalized for Stage 2.

CMS also proposes to retain the group reporting option for Comprehensive Primary Care (CPC) initiative practice sites as finalized in the CY 2014 PFS final rule, but to relax the requirement for the CQMs to cover three domains under the National Quality Strategy (NQS). We are opposed to relaxing the reporting requirements for CPC participants to only report measures in 2 domains instead of 3. We do not find CMS's explanation that CPC sites are measured in non-MU ways that cover other domains compelling. Consumers and purchasers want to see measures across these important domains reported electronically. We also believe that there are sufficient measures available in all the domains for the practice sites to choose from and that the practice sites should have no difficulty identifying 9 measures that cover 3 domains from the available list.

MEDICARE SHARED SAVINGS PROGRAM

Proposed Measures to Assess the Quality

At the launch of the Medicare Shared Savings Program (MSSP), CMS indicated it would not change the measures used to assess quality of care for the first three years to maintain consistency in the program. Thus, the proposed changes to the current measure set represent the first significant change in performance measures required by MSSP participants. CMS is proposing to:

- Assess quality with 37 measures, rather than the current 33 measures, beginning with the 2015 reporting period;
- Add twelve new measures and retire eight existing measures; and
- Maintain four composites with equal weighting: Patient/Caregiver Experience; Care Coordination/Patient Safety; Preventive Health; At-Risk Populations.

We think the measure set should include outcomes measures, both clinical and patient-reported, as well as measures that address care coordination. Consequently, we continue to remain very supportive of including Clinician/Group CAHPS (Measures 1-6), Medicare Advantage CAHPS: Health Status/Functional Status (Measure 7), Risk-Standardized, All Condition Readmissions (Measure 8), Care Coordination/Transition measures (Measures 9-11).

⁸ Consumer-Purchaser Alliance Comments on Proposed Modifications to Medicare and Medicaid Electronic Health Record Incentive Programs for 2014: <http://www.consumerpurchaser.org/files/MU3delay.pdf>

Additionally, we are supportive of the proposed addition of the following measures:

- CAHPS: Stewardship of Patient Resources (Measure 34)
- Skilled Nursing Facility 30-Day All-Cause Readmission (Measure 35)
- All-Cause Unplanned Admissions for select conditions (Measures 36-38)

We are particularly pleased with the inclusion of a measure we previously recommended, Depression Remission at Twelve Months (Measure 40). Depression is an under-diagnosed and debilitating condition that can impact many aspects of life, including taking care of other health conditions.

We are concerned that there remains a reliance on process measures in the set. For example, Documentation of Current Medications in the Medical Record (Measure 39) is a “check-the-box” measure that documents steps a provider has taken, but tells us little about the quality of care provided or its outcomes. In fact, there is a poor relationship between such measures and patient outcomes.⁹ In some cases, the process measures are included individually as well as in a composite. We support inclusion of process measures in composites, particularly if they are based on a patient-centered approach (i.e., the patient has received all indicated tests and treatments known to provide significant positive health effects for their condition). We recommend retaining the Diabetes and Coronary Artery Disease Composites and removing the individual measures from the incentive calculation. In regards to the Diabetes Composite, controlling high blood pressure is a critical element to achieving optimal care. We believe Blood Pressure <140/90 (Measure 24) should not be removed from the set and should be included in the Diabetes Composite. While there is overlap with HTN: Blood Pressure Control (Measure 28), removing it lowers the standard for diabetes care. Three Aligning Forces for Quality Communities – Cleveland, Humboldt and Minnesota – as well as IHA use an optimal diabetes composite that includes blood pressure control.

Additional Measure Recommendations

When patients are informed and effective managers of their health, this can lead to improved patient satisfaction but also improved clinical outcomes and lower health care costs.¹⁰ Engagement and “activation” become particularly important for patients with chronic conditions because patients can play an important role in their ongoing care and functioning. To facilitate better, more appropriate engagement tailored to individual patients we encourage CMS to consider developing a public domain performance measure of clinician use of the Patient Activation Measure (PAM) survey as a reporting requirement (not performance score). The PAM, developed by Dr. Judith Hibbard, helps categorize how activated a patient is in their care by assessing skills, knowledge, beliefs, and behaviors. By knowing a patient’s stage of activation, providers can tailor care plans that better meet their patient’s needs. Research indicates that the use of PAM leads to better outcomes. The PAM

⁹ Chassin M, Loeb J, Schmaltz S, and Wachter R, “Accountability Measures — Using Measurement to Promote Quality Improvement,” *New England Journal of Medicine*, June 2010. <http://healthcarereform.nejm.org/?p=3580>.

¹⁰ Greenfield S, Kaplan S, Ware JE Jr. Expanding patient involvement in care. Effects on patient outcomes. *Ann Intern Med* 1985;102(4): 520-8.; Greenfield S, Kaplan SH, Ware JE Jr., et al. Patients’ participation in medical care: effects on blood sugar control and quality of life in diabetes. *J Gen Intern Med* 1988;3(5): 448-57.; Kaplan SH, Greenfield S, Ware JE Jr. Assessing the effects of physician-patient interactions on the outcomes of chronic disease. *Med Care* 1989;27(3 Suppl): S110-27.)

has undergone significant testing and is considered to be a valid and reliable instrument. This measure is in use in a CMMI funded ACO project run by the Pacific Business Group on Health known as the Intensive Outpatient Care Program.

We strongly support the use of the Patient-Reported Outcomes Measurement Information System (PROMIS). PROMIS measures patient-reported functional status. Patients deserve to know whether treatments that are intended to improve their functional status actually make a positive difference. Measuring functional status is also important to assessing appropriateness of care and whether a treatment was effectively administered. PROMIS promotes parsimony because it is cross cutting. It provides a stable of “general” surveys that can be used to measure patient functioning in various clinical areas. We recognize PROMIS may not be ready for “prime time” use in MSSP and emphatically encourage CMS to lay groundwork for its use. CMS should also consider collaborating with the Patient Centered Outcomes Research Institute in moving this work forward on a fast track.

Coordinated care is an essential element to providing better quality, more affordable care in ACOs. Good care coordination is particularly important for vulnerable older adults, who typically use the most health care services but have the poorest health outcomes. We suggest CMS consider including the Care Transitions Measure 3 (CTM-3) as a stand-alone metric within the Medicare Shared Savings Program (ACO) measure set. The CTM-3 measures the extent to which patients are being prepared to participate in post-hospital self-care activities; CMS has recently incorporated CTM-3 into the HCAHPS survey. The CTM-3 includes the three major domains that patients have identified in qualitative studies as critically important to their experience with coordination out of the hospital; namely understanding one’s self-care role in the post-hospital setting, medication management, and having one’s preferences incorporated into the care plan.

For future measure sets for the MSSP, we recommend CMS focus on including measures of outcomes, functional status, care coordination and patient experience. These are areas that call for the urgent investment of measure development funds. We recommend that CMS consider including measures of caregiver experience and efficiency as well.

Quality Performance Benchmarks

CMS establishes quality performance standards to assess the quality of care provided by ACOs. Under the current program, CMS set the standard of complete and accurate reporting of quality measures for the first year (essentially pay-for-reporting). During subsequent years, standards are phased in such that assess the ACOs are assessed on their performance of certain measures (i.e., some measures remain in the standard for complete and accurate reporting and others are based on actual performance). Quality performance benchmarks and minimum attainment are set based on Medicare Fee-For-Service data. CMS is proposing for second or subsequent agreement periods that the first year will not be pay-for-reporting for measures that were pay-for-performance in the prior agreement. We strongly support that approach.

CMS is also proposing to adjust the quality performance benchmarks for “topped out” measures to accommodate the belief that it may be harder for larger organizations to perform as well on these measures than smaller organizations. We do not support this approach as we believe it contradicts a patient-centered approach to performance. That is, from the patient’s perspective all providers should be held to the same standard of care. Furthermore, we have concerns about the measure set

including topped out measures. The Affordable Care Act directs the Secretary to “improve the quality of care furnished by ACOs over time by specifying higher standards, new measures, or both” and leaving topped out measures as pay-for-performance does not evolve the standards and ultimately is a disservice to Medicare beneficiaries.

Finally, CMS is also proposing to include additional rewards for quality improvement. The current program is designed to reward improvement by increasing the share in savings for ACOs that perform better on measures. However, the reference population for establishing benchmarks changes over time as participants join (or leave) ACO programs (MSSP and Pioneer) and PQRS. While the proposal to maintain benchmarks for two years creates some stability, it is possible that the benchmarks could decrease over time and reward performance that is not reflective of improvement. Thus, we support the proposal to reward ACOs that improve scores on individual measures from year to year as that is a more effective mechanism for rewarding improvement. We are however concerned that just adding this incentive to the program without making adjustments to the current pay-for-performance program may not evolve the ACO program to higher standards.

VALUE-BASED PAYMENT MODIFIER

The Value Modifier (VM) provides for differential payment to a physician or group of physicians under the Fee Schedule based upon the quality of care furnished compared to cost during a performance period. The ACA requires a transitional approach to implementing the Value Modifier, beginning with application to specific physicians and groups of physicians on Jan. 1, 2015 and transitioning to all physicians no later than Jan. 1, 2017. The Secretary of HHS may exercise discretion with respect to the specific physicians and physician groups to which the Value Modifier will apply prior to 2017.

We are pleased to see that three additional outcome measures will continue to be included in the quality measures used for the VM in CY 2016. We are supportive that the following measures will apply to groups subject to the VM: 1) a composite of rates of potentially preventable hospital admissions for heart failure, chronic obstructive pulmonary disease, and diabetes; 2) a composite rate of potentially preventable hospital admissions for dehydration, urinary tract infections, and bacterial pneumonia; and 3) rates of an all-cause hospital readmissions measure. We hope to see other outcome measures added to the program quickly.

To date, the VM has applied to physicians only; however, the Secretary has statutory discretion to apply the VM to non-physician EPs including physician assistants, nurse practitioner, clinical nurse specialists, certified registered nurse anesthetists and others starting in 2017. We are supportive of CMS’s proposal to apply the VM to groups of 2 or more physician and non-physician EPs and to solo practitioners in 2017, including groups that consist only of non-physician EPs.

In the CY 2014 final rule, CMS proposed to increase the downward adjustment under the value-based payment modifier from -1.0 percent in CY 2015 to -2.0 percent for CY 2016. We are supportive of CMS’s current proposal to increase the downward adjustment under the VM from -2.0 percent in the CY 2016 payment adjustment period to -4.0 percent for the CY 2017 payment adjustment period for those groups and solo practitioners that do not meet satisfactory quality reporting requirements for the PQRS.

CMS is also proposing to increase the maximum downward adjustment under the quality-tiering methodology to -4.0 percent for groups and solo practitioners classified as low quality/high cost and to set the adjustment to -2.0 percent for groups and solo practitioners classified as either low quality/average cost or average quality/high cost. CMS is additionally proposing to increase the maximum upward adjustment under the quality-tiering methodology. We support the proposed changes to the quality-tiering adjustments; however we offer additional comments below on the application of quality-tiering.

Quality-tiering, which evaluates performance on quality and cost measures for the VM would apply to all groups and solo practitioners for the 2017 VM. However, groups with 2-9 EPs and solo practitioners would be held harmless (only upward or neutral adjustments) while groups with 10 or more EPs could also receive downward adjustment. We appreciate CMS's phased-in approach to applying the Value Modifier, however we are concerned with a potential unintended and undesirable consequence: because the planned quality-tiering will exempt smaller group practices from downward payment adjustments, most of the VM penalties could fall on the shoulders of primary care physicians, who tend to practice in larger groups, while a large percentage of specialty physicians, who tend to practice in smaller groups, will be exempted. We therefore recommend that payment adjustments apply to all groups, regardless of size.

Additionally, we are supportive of CMS proposal to allow groups with two or more EPs to elect to have the CAHPS for PQRS survey measures collected in 2015 included in their quality of care composite for the 2017 VM. As noted above, we strongly support use of patient experience measures as a key dimension of performance accountability and, as such, support use of CAHPS metrics.

Ultimately, while we are supportive of CMS proposed changes to the VM, we believe that a 4.0 percent adjustment is not sufficient to incentivize physicians to improve quality. We continue to support tying a larger percentage of physician payment to the Value Modifier as CMS continues to improve and refine the measures included in its programs. Overtime, as CMS begins to adopt a more robust set of outcomes measures, CMS should increase the proportion of physician payment to the Value Modifier, eventually reaching at least 10%.

There is evidence in the private sector that higher incentives and penalties have a greater impact on quality improvement. For example, Wellpoint physician incentive programs, tailored to specialty physicians and to medical groups, have increased reimbursement by 5 to 10 percent or higher of total payments to reward high performing physicians. Wellpoint's surveys indicate this is a level more likely to affect behavioral change in physician practice.¹¹

Independent research published in the *American Journal of Managed Care*, indicates that prior readiness to meet quality standards is not the primary cause for physician participation in pay-for-performance (P4P) programs. Researchers demonstrated that the physician participation rate in P4P went up as a linear function of the reward level, indicating that most of the variation in physician participation

¹¹ See, Samuel Nussbaum Testimony to MedPAC on quality measures in private plans.
http://www.medpac.gov/transcripts/0905_allcombined_transc.pdf

decisions can be explained by the amount of the available financial reward.¹² Experts specializing in physician programs have suggested that 10-20 percent of physician pay should be performance-based in order to incentivize physicians to track their performance.¹³

Methodological Refinements to Address NQF Issues Regarding the Total per Capita Cost Measure

CMS proposes, beginning with the 2017 Value Modifier, to address two issues that the NQF Cost and Resource Use Committee raised in its review of the total per capita cost measure (the Committee narrowly voted against the measure).

The first change addresses the attribution process and the role of non-physicians in providing primary care. CMS proposes modifications to its two-step attribution methodology to allow for consideration of primary care services furnished by non-physicians during the first phase (the methodology currently assigns beneficiaries to the group who had a plurality of primary care services rendered by only primary care physicians in the group). We support this modification as it better reflects current practice of many physician groups that have a team of professionals to support patient care.

The second change addresses exclusion of part year Medicare beneficiaries and capturing end-of-life costs. CMS proposes to reverse the current exclusion of beneficiaries who are newly enrolled to Medicare during the performance period and enrolled in both Part A and Part B to capture end-of-life costs. Again, we support this modification as it improves the accuracy of total per capita costs. Of total Medicare spending, about 28% is spent on patients' last six months of life.

As stated above, we support CMS making these two changes for the total per capita cost measure reviewed by the NQF Cost and Resource Use Committee. We also support applying these modifications to other total cost of care measures that will be included in the Value Modifier program.

¹² de Brantes F, D'Andrea G, "Physicians respond to Pay-for-Performance incentives: Large incentives yield greater participation", *American Journal of Managed Care*, May 2009

¹³ See, R. Adams Dudley, MD, MBA presentation to CMS, "Using Physician Pay-for-Performance to Improve Care." <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/VBP-Final-508-0229-.pdf>