

Consumer-Purchaser DISCLOSURE PROJECT

Better information. Better decisions. Better health.

September 4, 2012

Marilyn Tavenner, M.A.
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services

RE: Response to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2013 Proposed Rule (CMS-1590-P)

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 inform consumer choice, payment, and quality improvement. We appreciate the opportunity to comment on the Payment Policies Under the Physician Fee Schedule and other Revisions to Part B for CY 2013 Proposed Rule.

The Medicare physician fee schedule and related regulations are vitally important to moving our health care system forward to reward and foster better quality and value. Some of the proposed changes are steps in the right direction. We believe that CMS' leadership is critical to more rapidly advancing a system of care that rewards quality, value, and coordination of care instead of the volume of services provided. We also strongly believe the needs of patients have to be a higher priority in the design of these programs. While supporting physician participation is an important goal, we must not lose sight of the underlying imperative to transition towards patient-centered care and away from current physician-centric approaches.

Below are recommendations on how to prioritize the needs of patients and others who pay for their care while reducing the amount of effort physicians expend on measurement so they can devote more time and other resources to their patients. We offer detailed recommendations in the Appendix, many of which are based on the following strategies that CMS should adopt:

Use a parsimonious core set of high impact measures that support achievement of HHS' Triple Aims. Employing a core set of high-value measures drives attention to areas of high impact and focuses efforts on areas of greatest importance. The core set should include measures applicable to a wide range of clinicians, as well as measures that apply to specific subsets of clinicians. Patient experience, intermediate and other outcomes, appropriateness, resource use, and cost of care should be the cornerstones for the initial set of measures. In the absence of "good" outcome measures, process measures with known and proximal relationship to the outcome can be included.

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Identify the ideal dashboard of measures and chart a course for reaching the destination. We need a roadmap on how to fill in the gaps in measures so we can collectively make judicious use of resources. If a measure set cannot address a specific area due to lack of measures or other limitations, a clear course of action to fill the gap should be identified. For example, CMS should also adopt an aggressive timeline to integrate meaningful specialty care measures, including patient-reported outcomes. The Measure Applications Partnership is a possible venue where this could occur.

Improve the Resource-Based Relative Value System. Payment reform will not reach its full potential if it continues to be based on a system that is inherently flawed. As new payment systems are likely to stem from the current fee-for-service payment system, it is necessary to correct the most glaring flaws of the current system. This should include rebalancing payments between primary care and specialty services so that patients can be assured of an adequate supply of primary care practitioners who will be essential contributors to a transformed health care system.

Align select program activities within Medicare and across other payers. Alignment within Medicare creates synergies across public programs and reduces the amount of effort physicians expend on data collection. Additionally, alignment between public and private sector initiatives increases the collective impact of these efforts and ensures that all parties are “rowing in the same direction.” CMS should borrow design elements from the private sector that have already successfully rewarded physicians for providing high quality, safe, and efficient care. Clearly, CMS should avoid counterproductive alignment that does not improve the value of programs by, for example, aligning them around weaker or less meaningful measures.

Encourage individual accountability and shared accountability. CMS will achieve the greatest improvements if it promotes both individual and shared accountability among providers. Individual physician accountability reinforces professional motivation for quality improvement, facilitates robust information for patients to use in choosing physicians, and identifies variation and improvement areas that would otherwise be masked by higher levels of aggregation. We strongly urge CMS, therefore, to incorporate physician-level performance in its near-term rule-making on payment and reporting. Shared accountability supports team-based care, coordination across providers, and progress toward a genuine “system” of care, rather than the siloed non-system we have today.

If you have any questions, please contact either of the Consumer-Purchaser Disclosure Project’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

AFL-CIO

The Alliance

Advocacy for Patients with Chronic Illness, Inc.

American Benefits Council

American Federation of State, County & Municipal Employees

American Hospice Foundation

Business Healthcare Group of Southeast Wisconsin

CalPERS

Childbirth Connection

Culinary Health Fund

The Empowered Patient Coalition

Health Policy Corporation of Iowa

Iowa Health Buyer's Alliance

The Leapfrog Group

Midwest Business Group on Health

Minnesota Health Action Group

National Business Coalition on Health

National Partnership for Women & Families

New Jersey Health Care Quality Institute

Northeast Business Group on Health

Pacific Business Group on Health

PULSE of America

St. Louis Business Coalition on Health

Unite HERE Health

APPENDIX

The following comments reflect a combined consumer, labor, and purchaser perspective on issues and questions raised in the Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2013 proposed rule. We appreciate the amount of work that goes in to developing and maintaining these regulations. Thank you for considering our comments.

MEDICARE TELEHEALTH SERVICES FOR THE PHYSICIAN FEE SCHEDULE

Medicare telehealth services benefit patients who live in rural areas and may have reduced access to care. We support adding preventive services that are now available without cost sharing under the Affordable Care Act to the list of Medicare telehealth services (i.e., screening and behavioral intervention for alcohol misuse, screening for depression in adults, screening and behavioral counseling for sexually transmitted infections, and intensive behavioral therapy for cardiovascular disease and obesity).

PRIMARY CARE AND CARE COORDINATION

Primary care and care coordination are critical components to achieving better health and reduced costs. CMS has a variety of initiatives to promote and adequately pay for the provision of these services, such as evaluating misvalued E/M services, ACO programs, and multi-payer advanced primary care practice demonstration. Additionally, the Affordable Care Act includes a short-term fix by temporarily increasing primary care payments. CMS offers two additional interventions to add to its portfolio of activities to encourage better primary care and care coordination:

1. Post-discharge transitional care management

Care management involving the transition of a beneficiary from care furnished by a treating physician (at a hospital, skilled nursing facility, or community mental health center) to a beneficiary's primary community physician can improve health outcomes and avoid costly services, such as preventable readmissions. CMS proposes to create a new HCPCS G-code to cover specific post-discharge transitional care management services that support the patient's physical and psychosocial health. We support the addition of this new care transition code. We believe this fosters shared accountability across providers for an episode of care, including the avoidance of avoidable hospital readmissions.

2. Advanced primary care practices

CMS is considering providing additional payments to providers that are advanced primary care practices, or medical homes. The payments could be based on satisfactorily meeting national accreditation standards, CMS-developed criteria, or other alternatives. Given that medical homes and accountable care organizations (ACOs) share similar features, an additional possibility would be to base payments to these practices/entities on value, as in the ACO programs (which initially includes incentives in a fee-for-service environment with the goal of moving to global payment). Specifically the ACO model emphasizes paying for performance while also requiring certain functions (HIT capabilities, use of plan of care, etc.). CMS-developed criteria would likely drive more standardization in the medical home certification/accreditation programs that are available from four organizations. However, CMS should build on the standards developed by NCQA and strengthen them, particularly in the area of quality measures

and patient engagement, so we do not create re-work. Ultimately, we believe it is more effective to pay these practices based on their proven ability to deliver better value.

We also want to underscore that we do believe primary care is undervalued and this needs to be addressed. This should include rebalancing payments between primary care and overpriced specialty services.

PHYSICIAN QUALITY REPORTING SYSTEM (PQRS)

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. In 2015, the Affordable Care Act transitions PQRS to a penalty-based program. Few substantive changes are suggested in the proposed rule. In our view, this is a missed opportunity for CMS to incent more substantial advances in better care. Since CMS is using PQRS as a building block for alignment with other programs, it is important to strengthen the program. Below we provide recommendations for accomplishing this objective.

Improve the current set of measures

While there is an over abundance of discrete process measures that reflect basic competencies of care (which lack evidence linking them to improved outcomes), CMS has taken steps to include outcome measures. CMS should continue to rapidly move down this path and we recommend the following actions:

- Create a core set of high-value measures that drives attention to areas of high impact and focus efforts on areas of greatest importance. The measure set should be limited to those measures that emphasize where physicians should focus to achieve the goals set forth in the three-part aim. The core set should include measures applicable to any clinician to permit maximum participation in the program. As a step toward implementing a core set, CMS should remove the broad flexibility in the current program by reducing the number of potential measures participants could collect and report. Additionally, CMS should collect three of the same type of high-value measures on all clinicians, such as outcomes, patient experience, and cost.
- Measures of process of care should be de-emphasized (either removed or down-weighted), and physicians should be accountable for outcomes of care; this moves away from micro-managing how physicians work to achieve outcomes and can substantially reduce reporting burdens.
- Similarly, CMS should add meaningful measures that fill current gaps. For instance, CMS should begin requiring patient-reported outcome measures for high cost, high volume services, e.g., total joint replacement and advanced cancer care. Instead of asking physicians to report on whether or not they conducted a functional health assessment, CMS should require reporting of the change in health status from one period to another.
- See Tables 1 and 2 at the end of this document for specific recommendations on measures to drop and add.

Support to enable reliable reporting at the individual clinician level

- We are concerned that lowering the minimum sample size from 30 to 20 will make it even harder to report results on individual physicians. As an alternative, instead of

lowering the sample size for everyone, we propose allowing clinicians to report on all their patients if they cannot meet the 30-patient threshold.

- We suggest increasing the sample size for larger group practices to support reporting on individual clinicians. Using a reliability threshold of 0.70 is an alternative in lieu of, or in conjunction with, a minimum sample size.
- Move to only a 12-month reporting period. This supports obtaining an adequate sample size.
- Return to using a threshold of 80% of Medicare Part B patients for claims-based reporting. The 50% threshold jeopardizes reliability and public reporting of performance.
- We strongly support the addition of composite measures. Not only is it a mechanism to help with reporting on an individual physician level, displaying summaries is consumer-friendly.
- Another technique to support individual physician level reporting is to use a “blended formula” of individual and group results. That is, individual physician and their medical group performance should be blended to produce physician-specific results.

Alignment with other Federal programs

We strongly support consistency of methods and measures across a variety of HHS initiatives. We are pleased that CMS is now able to accept information for eligible professionals on clinical quality measures electronically for the Meaningful Use program. We also strongly support replacing the GPRO web-based interface measures with those used in the Medicare Shared Savings Program.

Implementation of Maintenance of Certification requirement

As required by the Affordable Care Act, physicians are eligible for a 0.5% bonus payment add-on to PQRS for Maintenance of Certification (MOC) participation through 2014. We support the proposed self-nomination and qualification process.

Additional comments on the PQRS program

- CMS should **require physicians and other clinicians to report more measures** to create a better picture of the quality of care they provide. With the exception of the group reporting option using the web-interface, PQRS continues to require too little of eligible professionals, who, for the most part, only need to report on three measures of their choice – a standard in place since 2007. This is a fundamental flaw in the program, since clinicians rarely perform uniformly well or badly across the spectrum of patients and conditions they encounter. Allowing choice of measures permits “cherry-picking” and does not give an accurate picture of a physician’s practice.
- We support changing the **definition of group practice** to be 2 or more eligible professionals.
- We support **allowing group practices to use other reporting options** besides GPRO web interface.
- We strongly support the **new administrative claims reporting option and the measures** included in that set.

- CMS should require eligible professionals to **collect information on patient race, ethnicity, preferred language, disability status and gender** in order to measure and address disparities. We suggest that CMS use the HHS and OMH standards for race, ethnicity and disability status, and to use as many of the more granular language standards recommended by the Institute of Medicine as feasible.

ELECTRONIC PRESCRIBING (eRX) INCENTIVE PROGRAM

The Electronic Prescribing (eRX) Incentive Program was implemented in 2007 to provide incentive payments to eligible professionals for electronically prescribing medications for Medicare patients seen in their offices. Penalties for eligible professionals who are not successful e-prescribers begin in 2012. Both the eRX and Meaningful Use programs share the common goal of encouraging eligible professionals to adopt electronic prescribing. We believe the Meaningful Use program has more rigorous standards so we support the participation or demonstration of intent (through registration) to participate in the Meaningful Use program as an exemption to the eRX program. In the spirit of alignment with other programs, we also support changing the group practice definition to be 2 or more eligible professionals.

PHYSICIAN COMPARE

The ACA mandates the creation of Physician Compare to help Medicare beneficiaries make informed decisions in selecting physicians and to provide transparency in physician performance. It was launched a year and a half ago with basic information about Medicare providers, along with an indication of participation in the Physician Quality Reporting System and Electronic Prescribing Incentive Program. The ACA requires CMS to implement a plan by January 1, 2013 for full implementation of Physician Compare in accordance with the law. The ACA also mandates 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.

CMS should move quickly to implement the measures that are salient to beneficiaries. CMS should be investing in the development/refinement of measures to create this capability as it discontinues measures that distract and divert resources from measures that are more meaningful to patients. We are pleased to see the addition of high-value measures to this program. However, there is still an overreliance on process measures that are not linked to outcomes and provide minimal utility to consumers in comparing providers. The agency should shift away from measures of process and center its work on a narrower set of high-value measures, such as those required by ACA for this program. Additional comments on the measures include:

- We enthusiastically support publicly reporting 2013 patient experience information, especially for the individual physician. Consumers find information from other patients helpful. Furthermore, there is a body of evidence demonstrates that improving patient experience is directly linked to improvements in health outcomes, so public reporting also promotes quality improvement.
- We support the public reporting of ambulatory care sensitive condition measures of potentially preventable hospitalizations. Like patient experience, this should start with 2013 data.

- As noted above, we strongly support the addition of composite measures. Not only is it a mechanism to advance reporting on an individual physician, displaying summaries is consumer friendly.
- We advise CMS to be judicious in indicating clinician participation in programs and only use a select few, such as Meaningful Use. We are concerned about needlessly confusing consumers with programs they may be misconstrued by assuming a level of quality that is not correct. Participation in programs has not been linked to higher quality.

CMS has been slow to provide performance information at the individual physician level. We are disappointed that, for 2013, CMS plans to make only group practice performance results from PQRS available on the website. This is too high a level of aggregation to be meaningful to patients or to help them choose a physician. Consumers need and want information how well individual physicians care for their patients. Practice group level data are not always representative of an individual physician's performance because the way physicians within the same group practice care for their patients can vary significantly. Furthermore, individual physicians greatly impact the care that a patient receives. Making comparative information available on individual physician performance within a practice can also be a powerful motivator for change in a team-based context. CMS should implement our recommendation under the PQRS section for increasing reliable reporting of performance at the individual physician level. While we understand there are methodological challenges in reporting individual-level information, we urge CMS to address these issues as quickly as possible. **In the meantime, 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.**

VALUE-BASED PAYMENT MODIFIER

The Affordable Care Act (ACA) requires the establishment and implementation of a Value-Based Payment Modifier (Value Modifier) that provides for differential payments to physicians under the physician fee schedule based upon the quality of care furnished compared to cost. The law stipulates that this "value" modifier must be implemented in a budget-neutral manner. 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. This program is an important component to transitioning Medicare to pay physicians for value. We note that as proposed, the participation of many physicians would not be based on the value they provide, but rather their participation in certain Medicare programs.

If the design of the value modifier is guided by the interests of those who receive and pay for care, beneficiaries will reap the benefits. Below are design principles that we suggest should guide the program's development.

- Include measures that have high impact and are important to patients.
- Encourage individual accountability while rewarding effective team-based care.
- Place a greater emphasis on achieving cost containment.
- Promote alignment between public and private sector initiatives.
- Over time, tie a substantial portion of physician payment to the Value Modifier.

Participation in 2015

The value modifier initially will apply to groups of physicians with 25 or more eligible professionals. Physician groups participating in the PQRS program will have the choice of

whether or not they participate. Physician groups not participating in the PQR program, however, will be penalized under the value modifier program. Specifically:

- Physician groups participating in PQR can opt not to participate in the program. They will not have any payment adjustments (0%). We expect that physician groups with low performance will elect this path.
- Physicians who participate in administrative claims data program of PQR will not be affected by value modifier payments (0%). Again, physician groups with poor data capabilities to support quality measurement and improvement will be likely to select this path, and we would expect they would also have low performance.
- Physicians in the Medicare ACO programs will not be affected by value modifier payments (0%).
- Physicians who do not participate in PQR will have a penalty (-1%).

While we support streamlining programs, we have longstanding concerns with the PQR program that we have shared in this and previous comment letters. As a result, we oppose the concept of tying participation in the value-based payment modifier with participation in PQR. The desire for alignment between these programs should be balanced with the need for an impactful program that meets the intent of the law: value-based purchasing for physicians. CMS should accelerate participation in the value-based purchasing program during the transition period by providing strong incentives to physicians. CMS also needs to clearly signal in this rule the transition period to having a downside (i.e., face a penalty for poor performance) for all who participate. As it stands, the program allows low performers to sit on the sidelines and not be penalized. Starting in 2016, all physician groups with 25 or more eligible professionals should participate in the incentive program. These physicians were afforded significant opportunity to understand their performance and make changes through participation in the PQR. Additionally, we believe physicians who participate in the administrative claims data program of PQR or the Medicare ACO programs should be given the option to participate in the value modifier this year. However, they should be required to participate in 2016. Finally, those physicians newly participating in 2017 should be given no more than a year before their payment is tied to value.

Measures

CMS adopted the set of measures for the program earlier this year. We appreciate that the set includes measures of intermediate outcomes, care coordination, adverse drug events, and total cost of care. CMS is also proposing a few changes to this measure set.

- We strongly support CMS' plans to measure all participants on four outcome measures (30 day post discharge visit, all cause readmission, composite of acute prevention quality indicators, composite of chronic prevention quality indicators).
- We also support CMS' plans to use risk-adjusted total per capita costs and per capital costs measures for four chronic conditions (COPD, CAD, heart failure, and diabetes). In determining the runout period, CMS should run the data to determine the appropriate timeframe. We believe the optimal time is when an extension of the time period minimally improves accuracy.
- We support the new measures in the administrative claims reporting option, but do not understand why it is only a subset of the measures in the PQR administrative claims option. CMS should align the programs and use the full set.
- See Tables 1 and 2 for recommendations on specific measures.

Domains, Composites and Scoring

CMS proposes to classify quality measures into the National Quality Strategy domains and the cost measures into total and condition-specific cost. CMS will calculate a standardized score for each measure in the domains, based on the difference from the national benchmark. Domain scores are the average of the measures within that domain. The scores for each domain will be averaged using an equal weighting method to arrive at a composite score, one for quality and another for cost. Under the quality-tiering approach, CMS would classify physicians based on high, average, and low quality in combination with low, average, and high cost.

- We support the notion of using the national mean as the benchmark as the program gets off the ground. However, the program structure raises challenges for determining the benchmark. Allowing providers to choose the measures they report could lead to inconsistent benchmarks from year to year that are not based on the full distribution of performance across all providers. Also, we assume providers will choose which measures on which they perform well, so the benchmark will be skewed. Ultimately, making all report on a common set (beyond the four outcome measures) will help solve this issue. CMS should set an explicit timetable to providers when they would expect this to happen.
- Equal weighting of domains is a valid approach to compositing. Attention should be given to the number of measures in each domain so that the differential weighting supports policy goals.
- Our preference is for the Total Performance Score model. It fosters programmatic alignment, as the linear model is used in the Hospital Value Based Purchasing and ACO programs. Additionally, it can better incorporate an incentive for significant improvement as well as attainment of a threshold.
- Focusing on outliers will do very little to improving care, especially at the group level. Most of the performance variation is masked at the group level as it hides the significant variation among physicians within those groups. Groups should be accountable for the within-group variation.
- We strongly encourage CMS to set the performance standards at a higher level in subsequent years.

Other comments

- We support CMS exploring a value modifier program for hospital-based physicians to be assessed based on the performance of the hospital at which they are based.
- We support having one national benchmark that is the same for individuals or groups.
- Likewise, benchmarks should be based on all physicians reporting on the measure and not stratified by specialty.

TABLE 1: Measures that should be removed from CMS PQRS program

Measure	Medicare Program	Reason	Replacement, if available
Back Pain: Initial Visit	PQRS #148	This measure only asks whether a physician <u>documented</u> in the medical record that the initial visit covered certain elements (e.g., pain assessment, functional status, patient history, etc.).	Overall, the clinical measures of low back pain that CMS proposes to use don't effectively address overuse. Instead, CMS should use NCQA's claims-based measure of "Low back pain: use of imaging studies" (NQF #0052). This measure is proposed for the value-based payment modifier. Reporting the results of a patient-reported outcome is much more valuable.
Back Pain: Physical Exam	PQRS #149	This measure simply asks if a physician conducted a physician examination if a patient was experiencing back pain. It reflects a commonsense practice that does not need to be measured.	Reporting the results of a patient-reported outcome is much more valuable.
Selection of Prophylactic Antibiotic—First OR Second Generation Cephalosporin	PQRS #21	Measure of basic competencies.	CMS' PQRS measure group for perioperative care focuses solely on process measures when there should be measures of outcomes that capture whether infection or venous thromboembolism occurred.
Heart Failure: Left Ventricular Function (LVF) Assessment	PQRS #198	It is a "check-the-box" measure that simply assesses whether the clinician completed an assessment. Rather, the measure should report the patient's health status so that the clinician can determine whether the patient is improving over time.	
Heart Failure: Weight Measurement	PQRS	This is a standard of care measure and should not be included.	
Community-Acquired Pneumonia (CAP): Vital Signs	PQRS #56	This measure only asks the physician to check a patient's vital signs. This is a very basic expectation of patient care.	
Asthma: Asthma Assessment	PQRS #64	This measure only asks a physician to "assess" a patient's COPD. The goal should be to report the outcome of care.	Minnesota Community Measurement's measure of Optimal Asthma Control factors in critical outcomes (e.g., patient survey of

			asthma control, ED visits, hospitalization, etc.)
Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation	PQRS #51	The clinician is only asked to "evaluate" a patient's health status.	
Acute Otitis Externa (AOE): Topical Therapy	PQRS #91	We question whether this measure even meets the "clinical importance" test, let alone meaningfulness to consumers.	
Chronic Wound Care: Use of Wound Surface Culture Technique in Patients with Chronic Skin Ulcers	PQRS	Measure of basic competencies and poorly specified.	
Chronic Wound Care: Use of Wet to Dry Dressings in Patients with Chronic Skin Ulcers	PQRS	Measure of basic competencies.	
Coronary Artery Disease (CAD): Symptom and Activity Assessment Management	PQRS #196	This is a documentation measure. Additionally this measure only requires that a clinician "document a plan of care to manage angina symptoms." This check-the-box measure will not improve patient outcomes. Rather, the goal of this measure should be report whether the patient's angina is getting better or worse. This is an ideal opportunity to introduce patient-reported outcomes.	
Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain	PQRS	This is a basic competency of care.	
Pregnancy Test for Female Abdominal Pain Patients	PQRS #253	This is a basic competency of care.	
Participation by a Physician or Other Clinician in a Systematic Clinical Database Registry	PQRS TBD		
Timely Follow-Up (Paired Measure)	PQRS TBD	This is compounded and gives credit for attempting to follow-up (as opposed to actually having a successful follow-up).	
Pediatric Kidney Disease: Adequacy of Volume Management	PQRS TBD	This is a basic competency of care. The outcome measure (NQF #1667) is sufficient.	
Community-Acquired Pneumonia: Assessment of Oxygen Saturation	PQRS TBD	This is a documentation measure.	

Tobacco Use: Screening and Cessation Intervention	PQRS #226	This does not measure whether a patient quit smoking.	Diabetes Mellitus: Tobacco Non-Use. This measure importantly captures whether a patient achieved "tobacco-free status"
Primary open angle glaucoma (POAG): Optic Nerve Evaluation	PQRS #12	This is a basic competency of care.	
Improvement in Patient's Visual Function within 90-Days Following Cataract Surgery.	PQRS	PQRS already contains a similar measure -- 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery, which is currently a PQRS measure (PQRS#191). CMS should avoid duplicating this measure.	

Table 2: Measures that should be added to CMS physician programs

Measure	Additional Comments
Diabetes Mellitus: Tobacco Non-Use	This measure importantly captures whether a patient achieved “tobacco-free status.” All too often, measures of tobacco use only include an “assessment” and “counseling,” which fail to report whether a patient quit smoking. Use it to replace PQRS measure #226.
Low-back pain: Use of Imaging Studies	Assesses important area of overuse. Should be added to the Back Pain Measure Group.
Potentially harmful drug-disease interactions in the elderly	
Clinician/Group CAHPS survey	Patient experience is a key piece of the “three-part aim.” Including this measure will align with CMS’ Shared Savings Program.
National Health Service’s Patient Reported Outcome Measures of hip and knee replacement	These are well-vetted measures that capture the patient’s perspective about the end result of care.
CMS Episode Grouper	We support this concept. The Episode Grouper is under development. A recommendation on the measures will be provided when the technical specification is available for review.
PHQ-9	This is a functional status measure that screens for depression. It is widely used to track health improvements for certain patient populations in the public (nursing home payment) and private (ACOs, regional collaborative) sectors.
PROMIS	A system of highly reliable, precise measures of patient-reported health status for physical, mental, and social well-being. We recommend that CMS begin including measures derived from PROMIS in selected specialty areas, e.g., oncology.
VR-12	A “generic” (not specific to condition) health related quality of life survey that is used in the Medicare Health Outcomes Survey. We recommend that that survey be administered periodically to beneficiaries with multiple chronic conditions (MCCs) to identify providers who are achieving better outcomes.