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

August 31, 2009

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Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

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**RE: CMS Proposed 2010 Physician Fee Schedule
Comments from National Consumer, Labor, and Employer Organizations**

Dear Ms. Frizzera,

The 24 undersigned organizations representing consumer, labor and employer interests are pleased to provide these comments regarding the proposed 2010 Physician Fee Schedule. 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. Many of the proposed changes represent steps in the right direction, but they are incremental and marginal improvements where bold changes are required. We believe that CMS' leadership is critical to advancing a system of care that rewards quality, value, and coordination instead of the volume of services provided. Although, in some instances, specific statutory authority will be necessary, we encourage CMS to actively pursue a course to rapidly:

- Restructure how care is paid for by shifting to payment models that encourage physicians to deliver appropriate, coordinated, and patient-centered care. This means shifting to payments that are performance-based, as opposed to volume-based payments that do not take quality into account. And while "pay-for-reporting" programs have helped prepare providers for payment changes, it is time to move beyond these programs to pay-for-performance. Such a shift will require rapid-cycle testing and implementation of innovative payment and delivery methods such as episode-based payment, medical homes, and accountable care organizations, to generate evidence of approaches that demonstrate value;
- Increase payments for providing primary care services by addressing the imbalance between primary care and other specialties;
- Ensure that CMS receives input from a broad range of stakeholders, including consumers who receive services, employers and independent experts who do not have a direct financial stake in CMS's decisions;
- Accelerate the collection and public reporting of data that paints a complete picture of a provider's performance, with particular attention to efforts to reduce disparities in care. Public reporting of individual provider performance data has been shown to foster accountability, and spur quality improvement in the health care system;
- Support the alignment and coordination of Medicare payment reforms with innovative payment systems used by private payers to promote better value; and

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- Promote greater physician use of health information technology at the point of care to foster clinical decision support and the efficient collection of performance information.

These overarching concepts are woven into our comments. We urge that CMS take the initiative now as its efforts can provide important building blocks for the payment reform that must occur in the coming years. Please note, that while our comments are largely organized in the order CMS requested in the Federal Register, our strongest recommendations address the larger issues of how to rapidly move to a patient-centered, value-based payment system. These issues are addressed in the section discussing "Transitioning to a Value-Based Purchasing Program."

UPDATING THE TECHNICAL SIDE OF THE RESOURCE-BASED VALUE SYSTEM

CMS uses resource costs as the sole basis of determining its payments to physicians. But in order to move to a payment system that rewards and encourages "value," CMS also needs to consider patient needs and the interests of society as a whole in its determination of the relative value of different services. We comment more on this issue in the discussion of moving Medicare to becoming a value-based purchaser of clinician services. In the context of the existing RBRVS-system, we commend CMS for proposing improved "technical" processes that engage independent experts, updates on resource costs for certain services, and new consideration of telehealth – all of which will likely improve the delivery of patient-centered appropriate care.

Creating a Separate Group Panel of Experts to Review Relative Value Units (Section IIF5)

We strongly support the Medicare Payment Advisory Committee's (MedPAC) recommendation that CMS establish an independent panel of experts to review relative value units (RVUs).

Currently, CMS' "technical" review of RVUs is significantly influenced by the recommendations of an outside committee housed at the American Medical Association (AMA): the Relative Value Scale Update Committee (RUC). The RUC is made up of physicians that specifically represent over two dozen medical specialties. Many of the RUC's recommendations are based on expert panels and qualitative, subjective assessments of the physician work and practice expense components of the RVU value. In response to CMS' request for comments, the RUC offers its recommendations on values for new services, and recommends adjustments to values for existing services on a periodic basis.

Given the cost of analyzing and proposing new or revised RVU values, great weight is given to the RUC's recommendations. CMS routinely accepts 90% or more of the RUC's recommendations. The result has been "substantially more increases in RVUs than decreases, even though many services are likely to become overvalued over time" (MedPAC, March 2006).

In response to these dynamics, MedPAC recommended that CMS develop a new, independent panel of experts to advise it on RVUs. MedPAC specifically suggests that the panel "include members who do not directly benefit from changes to Medicare's payment rates," such as medical economists, technology experts, and physicians who are employed by managed care organizations and academic medical centers (MedPAC 2006). We strongly support this recommendation and believe that that such a panel would help to address CMS' need for independent, high-quality information to inform the RVU review process.

In addition, we urge CMS to ensure that the voices of those who receive and pay for care are included in the panel to consider RVUs. This is particularly critical as CMS considers potential reform of RBRVS. The RUC's recommendations need to go beyond a technical weighting of resource inputs to include an explicit reflection of patients' needs and population health. Currently, the scope of the panel is narrow, focused on the review of RVUs, a highly technical enterprise that deals solely with estimating the resource costs used to provide each service.

Practice Expense (PE) Proposals for CY 2010 (Section IIA2)

CMS proposes to utilize the PE/Hour (HR) values developed using the American Medical Association's (AMA) Physician Practice Information Survey (PPIS). The PPIS is a multispecialty, nationally representative PE survey of physicians and non-physician providers (NPPs) administered by the AMA in 2007 and 2008. CMS is not proposing changes in the use of the PE/HR data in the current PE RVU methodology.

We strongly believe that Medicare should use the most current and accurate data to determine payments for providers. As CMS notes in the proposed rule, the SMS surveys CMS currently uses are from 1995–1999. The Medicare Payment Advisory Commission (MedPAC) has been calling for CMS to update its practice expense data since 2006. In its June 2006 *Report to Congress*, MedPAC stated that "the data source CMS uses to estimate total practice costs is dated and may not reflect the current practice patterns."[1]

To the extent PPIS represents the best currently available data source on physician practice expenses, it should be used in place of SMS data which contained data for only 26 physician specialties and no non-physician practitioners. By using the PPIS data, CMS will be able to make more informed decisions and update RVUs for all physician specialties concurrently.

Updating the Equipment Utilization Rate (Section IIA2c)

We strongly support CMS' proposal to change the equipment usage assumption from the current 50 percent usage rate to a 90 percent usage rate for equipment priced over $1 million. This update follows a MedPAC recommendation and will encourage more appropriate use of high-cost equipment, such as those used for imaging services. Medicare's current payment methodology overpays physicians for imaging equipment, creating dangerous economic incentives for physicians to supply more imaging services than clinically appropriate. The result is unnecessary care that is costly and fails to translate into better patient outcomes.

Restructuring the Geographic Practice Cost Indices (Section IIB)

The Geographic Practice Cost Indices (GPICs) are a component of the RBRVS method for reimbursing physicians. Currently, GPCIs only adjust payment by accounting for the geographic differences in the cost of practice across the country. While CMS does not propose any changes for GPICs, we recommend that CMS develop a proposal to restructure GPCIs such that they can become vehicles to foster better accountability for high-cost regions.

Changing GPCIs to consider relative regional costs is important given the evidence that high cost regions do not necessarily produce better care. In fact, there is extensive research indicating that lower-spending regions provide as good or better care than higher-growth,

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[1] MedPAC, *Report to the Congress: Increasing the Value of Medicare*. June 2006.

higher-spending regions.[2] According to Dartmouth Atlas researchers, differences in health care spending rates are largely attributable to "discretionary decisions by physicians, which are influenced by the local availability of hospital beds, imaging centers and other resources – and a payment system that rewards growth and higher utilization."[3]

CMS should address these regional variations by developing proposals for calculating GPCIs that consider vehicles such as temporarily adjusting the indices downward for high-cost regions. In developing payment adjustments of high-cost regions, CMS should articulate how such policies would consider the quality of care provided, impacts on potential access to care of payment changes, and ways that payment adjustments within a GPCI might vary by the type of service provided if some services are identified as being more significant contributors to high cost or high cost growth.

Expanding Medicare Telehealth Services (Section IID2)

Telehealth can be beneficial to patients, providers, and CMS. It can expand access to high-quality medical care, improve patient-provider interactions, and increase patient participation and self-care. We encourage CMS to expand the number of telehealth services eligible for reimbursement. Of course, any decision about services should be based on sound evidence.

Increased Payment for an Initial Preventive Physical Examination (Section IIE2)

We commend CMS for proposing to increase the Medicare payment for an initial preventive physical examination (IPPE). This change will bring the assigned value of the IPPE closer in line with other evaluation and management services conducted.

We believe that this proposal, if guided by the recommendation that IPPE adhere to the U.S. Preventive Services Task Force guidelines, will encourage the delivery of necessary preventive care. This is critical given the significant underuse of effective preventive care in the United States that results in lost lives, unnecessary poor health, and inefficient use of health care dollars.

Payment Changes for Consultation Services (Section IIE4)

A consultation service is an evaluation and management (E/M) service furnished to evaluate and possibly treat a patient's problem(s). Consultation services are largely performed by specialty physicians and paid at a higher rate than other E/M services because they are supposed to require more work. Under CMS' current policy, a consultation service must be requested by another physician or other professional and be followed by a report to the requesting professional. However, the distinction between a consultation service and other E/M services has become blurred as documentation requirements across all E/M services have become more comparable. The result has been that for comparable work specialists have been paid higher rates than primary care physicians. It is critical that Medicare begin to reduce the gap between payment for specialists and primary care. The undervaluation of primary care has

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[2] Skinner JS, Staiger DO, Fisher ES. Is technological change in medicine always worth it? The case of acute myocardial infarction. Health Aff (Millwood) 2006;25:w34-47.;. Fisher ES, Bynum J, Skinner J. The Policy Implications in Medicare Spending Growth. The Dartmouth Institute for Health Policy & Clinical Practices. February 2009. < http://www.dartmouthatlas.org/atlases/Policy_Implications_Brief_022709.pdf>
[3] http://www.dartmouthatlas.org/press/NEJM_Release_RWJF_022609.pdf

had severe consequences on the supply of primary care physicians, who are vital to caring for older Americans, and providing care coordination and preventive services.

We support CMS' proposal to eliminate consultation codes and to instead have these practitioners use existing E/M service codes. Resulting savings would be redistributed to increase payments (i.e., increasing estimated resource costs) for the existing E/M services. Overall, the shift from the consultation codes to the E/M codes should be budget neutral and have the effect of marginally increasing the relative payments made to primary care practitioners.

BOLSTERING THE PHYSICIAN QUALITY REPORTING INITIATIVE (Section IIG2)

Three years into the Physician Quality Reporting Initiative (PQRI), CMS should be expecting more from participating clinicians. Even with the proposed changes to PQRI, the data collected by CMS will only assess how participating clinicians care for a small portion of their patients. Further, there continues to be no clear path to making the results public. These proposals do little to foster accountability and quality improvement. Only practice group performance data will be made public; CMS will provide incentive payments to group practices, which must include over 200 individual professionals, for the first time in 2010. We believe CMS should move as expeditiously as possible to provide consumers with actionable performance data so that they can make informed choices based on quality and value. We do, however, commend CMS' push for EHR data submission, which will help to both encourage clinician use of HIT to provide improved patient care and facilitate better information collection.

For PQRI to reach its potential, we believe that it will be critical for CMS to:

- Transition PQRI from a program that rewards reporting into a program that rewards clinicians for performance;
- Significantly expand the number of measures and how many patients are reflected in measures;
- Assure that reporting for clinicians reflects the types services provided and mix of patients cared for; and
- Assure that performance results are publicly reported at the level of the individual professional whenever feasible.

PQRI can become a more powerful tool to advance quality of care, and we believe that CMS should seize this critical opportunity.

Transitioning from Pay-for-Reporting to Paying-for-Performance

CMS proposes to keep PQRI as a "pay-for-reporting" program, which provides little incentive for participating clinicians to improve care. It is time to implement a payment approach that distinguishes between lower-quality and higher-quality care, by transitioning to a pay-for-performance program for all participating professionals.

Reporting on a Greater Number of Measures and More Impactful Measures

CMS continues to recommend that participating individual professionals be required to select only three measures on which to report to qualify for bonus payments. We believe that PQRI

should expand the number of measures to create a comprehensive picture of the quality of care each participating professional provides. To minimize the burden on PQRI participants, we believe that expansion of measures should be linked to the availability of claims-based measures and the rapid implementation of electronic health records ("EHR") with "meaningful use" requirements that assure easy collection and automatic submission of measurement data in a standardized format.

We also recommend that CMS phase out the existing process by which participating professionals select the measures upon which they will be assessed. Instead, CMS should assign each participating individual professional with sets of measures for high-volume conditions, based on the services provided to their patient population. For example, if a large number of a participant's patients suffer from diabetes, CMS should assign a set of diabetes measures that will effectively reflect the overall care the participant provides to patients with diabetes. These measures should then be rolled up into a scientifically-based composite for the purposes of quality improvement, paying for performance, and public reporting.

In contrast to its proposal for participating individual clinicians, CMS proposes to require group practices to report on a more extensive number of measures. Each group practice would report on a common set of 26 National Quality Forum-endorsed quality measures that were used in its Physician Group Practice and Medicare Care Managed Care demonstration projects that target high-cost chronic conditions and preventive care. Quality measures will be grouped into four disease modules: diabetes, heart failure, coronary artery disease, and preventive care services. We support the use of these measures, although we note that collecting measures on patient adherence to treatment regimens may be challenging as the Medicare Part D data are often incomplete due to beneficiaries' self-pay for prescriptions in the "donut hole". For such measures we also encourage CMS to emphasize the use of electronic data reporting instead of manual chart reviews. While we commend this reporting for group practices, but believe that (1) reporting needs to done by composite for the four areas; and (2) that group practice reporting should be supplemented by reporting of individual professionals within the group whenever possible.

CMS should also assess and publicly report on how the measures it is using are assessing the extent and nature of the "patient-centeredness" of care, including efforts to reduce health disparities, enhance patient and caregiver experience of care, coordinate care for beneficiaries with multiple chronic conditions, and improve health outcomes and functional status.

Patient reporting requirements

Under PQRI, CMS is proposing separate reporting methods for individual clinicians and for group practices. Currently, individual clinicians have the choice of reporting on individual measures or measures groups. Measures groups are a subset of at least four PQRI measures that have a particular condition or focus in common. CMS offers individual clinicians three different methods for reporting the measures, one for individual measures and two for measures groups. In each of these cases, CMS proposes to either add or change minimum sample sizes, or change how physicians will select patients to report on.

> **Individual Measures:** Currently, CMS requires that individual clinicians, who are reporting on individual measures, report on at least 80 percent of eligible patients for each measure. CMS proposes to keep this requirement for 2010. Additionally, CMS proposes to add that individual clinicians must also meet a minimum patient sample size for at least one individual measure. The minimum sample size proposed would be 15

patients (for a full year of reporting) or eight patients (for a half-year of reporting). These two requirements would be applied to all reporting mechanisms (i.e., electronic health records, registries, claims), although half-year reporting would only be available for registry-based reporting. We support CMS' proposal to apply the same standards across all types of reporting mechanisms, but are very concerned that the minimum sample size requirements are not adequate. Studies have demonstrated the need for samples of 25 randomly selected patients for comparable measures. We also encourage CMS to consider the use of composites to help increase the reliability of individual physician performance data. Composites are generally more meaningful to consumers as well.

- **Measures Groups – Method 1:** In reporting a measures group for 2009, individual clinicians can select one of two methods. In the first method for measures groups, CMS currently requires that individual clinicians report on at least 80 percent of the patients for whom the measures group applies to, with a minimum of sample size of 30 patients (for a full year of reporting) or 15 patients (for a half-year of reporting). For 2010, CMS proposes to reduce the required minimum sample size to 15 patients (for a full year of reporting) and 8 patients (for a half-year of reporting). This change would apply to claims and registry based reporting (electronic health records will not be made available for measures group reporting). CMS proposes the reduction in order to make sample size requirements consistent with those proposed for individual clinicians reporting on individual measures. While we support CMS' proposal to use the same standards across different types of reporting methods, we are concerned that the minimum sample size requirements may not be adequate.

- **Measures Groups – Method 2:** Currently, the second way that individual clinicians can report on measures groups is by reporting on 30 consecutive, eligible patients for each measures group for a full year. For 2010, CMS proposes to do away with a portion of this requirement by allowing individual clinicians to select and submit **any** thirty eligible patients. We believe that removing the requirement for consecutive patients would run the risk of resulting in a non-representative sample of the overall care that providers supply; we therefore do not support this specific proposal and encourage CMS to assess other methods of easing collection burden on providers while assuring valid samples.

In the case of group practice reporting, CMS proposes to use a sampling method that is the same as that used in the PGP demonstration -- CMS will assign each practice group with a random sample of at least 411 Medicare beneficiaries. If the pool of eligible assigned beneficiaries is less than 411, then the group practice must report on 100 percent of the assigned beneficiaries to participate in the group practice reporting option. The proposed sample size of 411 is absolutely <u>not</u> an adequate sample size to report on the performance of individual clinicians in the group. To be able to report on individual clinician performance, the sample sizes should be increased to be comparable to the collections required for the sampling for individual clinician reporting. Only full year reporting will be offered to group practices.

Advancing Public Reporting of Provider Performance

For 2010, CMS does not discuss any plans to require public reporting of individual clinician performance on quality measures. We believe the time has come for public reporting, and that CMS needs to articulate a clear and aggressive path forward, with short-term benchmarks and a goal of having publicly available, actionable performance and cost information for all

participating Medicare clinicians. In an environment where consumers are being asked to take a greater role in their health care, consumers need access to information on how well their individual clinician delivers care. This information is critical to helping consumers make more informed decisions about their choice of providers and the care they receive. The availability of individual clinician performance data is also important to helping employers and third-party payers reward clinicians for quality rather than volume of care.

In the case of group practices, CMS proposes to require each participating group practice to agree to have its PQRI quality measurement performance rates publicly reported on a CMS website. We strongly support this proposal. As noted earlier, however, we do not believe that group-level reporting obviates the need for public reporting of the performance of individual clinicians.

CMS does propose to make public the names of participating individual clinicians (or group practices) who satisfactorily submit data on quality measures for PQRI. While this is a long way from reporting individual provider performance results, we support this effort and believe that CMS should also specifically identify clinicians who chose not to participate. The willingness (or lack thereof) of clinicians to participate in performance measurement and reporting should be publicly recognized.

Moving Toward Electronic Reporting of Data

For 2010, in addition to existing claims-based and registry-based reporting mechanisms, CMS proposes to offer electronic health record (EHR) data submission for a subset of individual PQRI measures. Availability of the EHR data submission method will be contingent on CMS' ability to test this mechanism in time.

We strongly support CMS' efforts to promote rapid transition to EHR data submission. This will encourage greater clinician use of EHRs as a part of normal workflow in every day patient care, and move us closer to the regular ability to collect and readily report far more robust performance measures.

While CMS proposes to maintain claims-based reporting mechanisms for 2010, we support the agency's plans to lessen PQRI's reliance on the claims-based mechanism of reporting clinical quality measures after 2010. This transition will depend on whether there are an adequate number and variety of EHR or registry-based reporting options available. CMS should focus concerted attention at making this transition as rapidly as possible.

New Criteria for PQRI Measures

Measures should only be included if they will reflect meaningful differences in the care received by patients and can make a tangible difference in the way clinicians care for their patients. CMS is proposing a set of criteria that measures must meet to be included in PQRI:

- NQF-endorsed by July 1, 2009 (any proposed 2010 PQRI quality measures selected from the 2009 PQRI quality measure set would need to have been adopted by the AQA as of January 31, 2009, if the measure still is not endorsed by the NQF by July 1, 2009)
- High impact on health care
- Address gaps in the PQRI measure set
- Technically implementable by CMS

We strongly support CMS' use of NQF-endorsed measures, but believe that in areas for which NQF measures are not available, CMS should use measures from other nationally recognized sources with the requirement that it move those measures quickly through the NQF endorsement process. In addition, we believe that CMS should consider four additional criteria in its selection of measures for inclusion in PQRI:

- Are relevant to consumers and purchasers, such as outcome and resource use measures
- Reflect the continuum of care and encourage care coordination
- Address appropriateness of care
- Are designed to allow for assessing and reporting on disparities of care

As PQRI data becomes publicly reported, measures must resonate with consumers and purchasers. Measures in the areas of care coordination and appropriate care are important because both areas have long been overlooked within the health care system, to the detriment of health outcomes, patient safety and value.

PHYSICIAN RESOURE USE MEASUREMENT AND REPORTING PROGRAM (Section IIG3)

CMS has currently underway the Physician Resource Use Measurement and Reporting Program to collect information on physician resource use from CMS and other data sources and provide confidential feedback on resource use measures to individual physicians in selected cities and specialties for high cost and/or high volume conditions.

Expanding the Program

For 2010, CMS is proposing to expand the program to physicians in more geographic locations. Also, reports would be provided not only to individual physicians but also to groups of physicians, such as group practices or physicians practicing in a facility or system. We strongly support expanding the measurement and reporting of resource use. Not only will the program build greater awareness of resource use among physicians and encourage accountable care, we believe that this program could serve as a potential building block for potential gain sharing and other pilots that will pay incentives to physicians for providing the best value.

As part of expanding the program, CMS is also proposing to add quality performance information with the comparative resource use information it provides to physicians. We strongly support reporting resource use information along with quality information – it is these two components together that reflect "value" that consumers and purchasers care about.

Beyond combining resource use and quality information, we recommend that CMS publicly report this information at all relevant levels; the data should be made publicly available at the individual practitioner level, as well as at higher levels of aggregation when appropriate. As the program continues to expand, we urge CMS to assure that sample sizes selected allow for meaningful comparisons, which will be critical as these measures are transitioned to be used to reward physicians for performance and for public reporting.

PLAN FOR TRANSITIONING TO A VALUE-BASED PURCHASING PROGRAM (Section IIG4)

We commend CMS and Congress for recognizing the need to transition Medicare to a value-based purchasing (VBP) program. Instead of paying physicians solely on the basis of quantity of services provided, as in Medicare's current FFS payment systems, VBP aligns payment more directly to the quality and efficiency of care provided by rewarding providers for their measured performance across multiple dimensions of quality. As required by law, CMS is developing a plan to transition Medicare payments for physician services to a VBP program. CMS first sought public input on its draft VBP plan in December 2008. CMS is now preparing the final draft of its VBP plan for a report to Congress, which is due May 1, 2010, and is seeking further comments.

We strongly support the goals, objectives and assumptions outlined in CMS draft VBP plan, and we provide recommendations on four areas of the VBP plan: (1) measuring physician performance; (2) payments/incentives; (3) data collection; and (4) public reporting. (Note: many of the signators to this letter have previously commented in more detail on these issues so the comments that follow are brief. The exception to this is the discussion of transitioning the RBRVS payment system to better reflect patient value, which we expand on under the section on payments/incentives.)

Measuring Physician Performance

We encourage CMS to focus on the types of measures referenced below:

- High impact on health care
- Technically implementable, ideally through collection in EHR
- Relevant to consumers and purchasers, such as outcome and resource use measures
- Reflects the continuum of care/care coordination
- Addresses appropriateness of care
- Designed to allow for assessing and reporting on disparities of care
- Measures patient experience (i.e., Clinician/Group CAHPS survey)

CMS should select measures that increasingly reflect dimensions of care that are meaningful to consumers and purchasers. We do not believe minimum standards of competence meet this criterion. Basic competency standards simply reward physicians for providing marginally effective care or care that should be routinely furnished; in addition, it sets up an uneven playing field as measures for some specialties are far more robust than for others.

Payment/Incentives

Payments should support the evolution of the health care system into one that delivers appropriate, high-quality, efficient, equitable, and patient-centered care. CMS should incorporate different payment methods that are specific to identified goals and accommodate different practice arrangements. We believe that performance incentives should be linked to assuring quality of care and maintaining access to Medicare providers, while fostering higher value and reductions in the growth of costs over time. We, additionally, believe that incentives should be structured to:

- Tie a substantial portion of CMS payment to performance, and increase that portion as the program matures.
- Reward a combination of achievement and improvement.
- Drive rapid re-engineering of care delivery and encourage the integration and delivery of services for those with chronic illnesses. For example, CMS should promote the rapid assessment and implementation of medical homes, broader use of nurses and team-based care, bundled and episode payments, and accountable care organizations.
- Recognize that efficient and effective care may reduce expenditures both within a single sector and between sectors, which requires thinking of payments and incentives outside of the current siloed Medicare payment structure. For example, physician services may reduce expenditures in emergency rooms and hospital care.
- Promote alignment and harmonization of payments among Medicare, Medicaid and private sector payers.
- Consider the value to patients and society rather than viewing "value" from the perspective of the provider of care.

In the section the follows, we expand in greater detail on how the last bullet of this list can be implemented. Specifically, we highlight the importance of transforming an important component of the existing Medicare FFS payment system, the Resource Based Relative Value Scale, to reflect the values of those who receive and pay for care,

Revising Medicare Fee-for-Service to Reflect Patient Value

CMS uses resource costs as the sole basis of its payments to physicians. As part of moving to payment systems that reflect value, the Resource Based Relative Value Scale (RBRVS) payment system needs to be overhauled to consider value from the perspective of the individual patient and the entire population in their design and in the input processes used to determine the relative value of different services.

To greatly improve quality of care, CMS must restructure how it pays for care. We recommend CMS begin this process by significantly modifying the RBRVS so that it reflects and incorporates the values of those who receive and pay for care.

- **The Current RBRVS System and Need for Change**

  RBRVS is the system CMS uses to make payments to physicians for treating Medicare beneficiaries. Under the current RBRVS framework, physician payments are based primarily on the resource cost of providing a service (i.e., work done by the physicians, malpractice insurance, and practice expenses including staff salaries, overhead, supplies, and equipment). There is no accounting for quality and no accounting for patients' needs or population health. Clinicians are implicitly discouraged from delivering 'low resource-using' services that might be highly valuable to a patient or from a public health standpoint (e.g., counseling, care coordination, shared decision-making, etc.). And because many private sector payers use variations of RBRVS to determine physician payment rates, its perverse incentives have implications across the health care system.

- **Proposed Development of Payments to Reflect Patient Value**

  We support rapid movement to a physician payment system that rewards value from the perspective of the individual patient and the entire population and resource use. We recommend that CMS develop a proposal to restructure the RBRVS system such that provider costs are not the sole factor for payment, but rather are considered along with other factors, such as the service's value to patients. The new 'value' factor should consider policy priorities, patient preferences, assuring Medicare is fiscally sustainable, payer and purchaser perspectives and be informed by additional considerations such as utilization patterns and geographic variation.

  The redesign of the RBRVS formula should include mechanisms to reward physicians for providing evidence-based care. Because the current payment mechanism fails to take into account the clinical appropriateness of the services provided, physicians have little incentive to adopt and use evidence-based guidelines that will help patients receive the right care at the right time. In fact, they are perversely rewarded for delivering inappropriate care and putting patients at risk.

  The proposed revision of the RBRVS should include mechanisms to issue differential performance-based rewards that account for increasingly substantial portion of payments. CMS should consider whether some identified services and providers have available to them larger performance-based payments to encourage care in areas of high need (for example, coordinating care or engaging a patient in shared decision-making).

- **Assuring Policies are Designed with Input from Consumers and Purchasers**

  As part of reforming the RBRVS, developing a Value-Based Purchasing program for Medicare requires that CMS sponsor input processes that assure its decisions are guided by independent experts, and those who receive and pay for care – while continuing to be informed by the clinicians who receive payments. One mechanism CMS should consider is convening a new advisory group, the Consumer and Health Care Purchaser and Provider Update Committee (CHUC), to inform CMS on how value from the perspective of the individual patient and the entire population could be integrated into the restructuring of RBRVS. The new advisory group should include patients, family care givers, purchasers, providers and payers – with majority representation by those who receive and pay for care -- and serve as a forum for broader multi-stakeholder input. The CHUC could also provide input on how patients' needs and population health can be incorporated into the basis of payment for all provider sectors to ensure consistent valuation of provider services and procedures.

Data Collection

As a first priority, measures should be derived from currently available electronic data that does not require additional coding by physicians. At the same time, we advocate that CMS continue to proactively pursue the submission of data via other electronic means, including EHRs.

We also recommend that CMS make physician-identifiable data available for merging with that of other payers to create "all payer" data so as to provide the best possible picture of providers' overall performance.

Public Reporting

The public reporting, scoring and the display of performance information should be done with consumer decision-making in mind. While there may be separate formats and delivery of information to clinicians to support quality improvement, we strongly support CMS in its efforts to ensure that performance information is accessible and useful by the consumer. Because there are a range of private sector organizations that work in the areas of both public reporting for consumers and supporting clinicians in their efforts to improve patient care, we recommend that CMS allow other organizations to have full access to physician and other professionals' performance information.

E-PRESCRIBING INCENTIVE PROGRAM (Section IIG5)

The E-Prescribing Incentive Program is designed to encourage eligible professionals to use electronic prescribing in patient care. Electronic prescribing applications have the potential to make tremendous improvements in patient care. They provide important clinical decision tools (i.e., drug-drug, drug-allergy, and drug-formulary checks) and have the ability to electronically connect clinicians to external sources to obtain a more complete picture of a patient's current medication list. In 2010, group practices participating in PQRI with at least 200 or more individual clinicians will be included in this program for the first time.

Reporting on More Robust Measures and a Significantly Larger Number of Patients

"Successful e-prescribers" receive incentive payments equal to 2 percent of their Medicare allowed charges. For 2009 CMS requires that successful e-prescribers report on relevant PQRI e-prescribing measure for at least 50 percent of eligible visits. Pursuant to the legislation, the Secretary can either continue with that 50 percent standard or propose a "sufficient number" of prescriptions to be classified as a successful e-prescriber. For 2010, CMS proposes that individual clinicians be considered successful e-prescribers if they report that at least one prescription was sent electronically for at least 25 separate visits in a year. To receive the incentive, CMS proposes that group practices would have to report that at least one prescription during an encounter was generated using an electronic prescribing system in at least 2,500 instances over the course of a year.

We are concerned that in its effort to enable all providers to be eligible for payment, that CMS may have set the bar far too low. As CMS states in the proposed rule, we agree that that the goal should be to "assure that those who have a large volume of prescribing do so electronically." If clinicians have an electronic prescribing system, they should be using the system to capture information for all prescriptions. While we are concerned that the 25 visit standard may set a "low-bar," we believe that a more important issue is for CMS to clearly articulate how it will align the definition of being a successful e-prescriber with the forthcoming meaningful use definition related to health information technology. In particular, the standards should come together in 2011 to promote the objective that for BOTH sets of incentives clinicians:

- Use CPOE for all orders
- Implement drug/drug, drug/allergy, drug/formulary checks
- Generate and transmit permissible prescriptions electronically (eRx)
- Maintain active medication lists

- Maintain active medication allergy lists

Related measures should be based on actual use of key functions. We are concerned that, in the absence of greater alignment, the proposed e-prescribing standard is inconsistent with the proposed meaningful use definition, and could undermine that definition and confuse clinicians.

We support CMS' proposals to expand the incentive program to include home care and skilled nursing care; this will help to extend the use of electronic prescribing for patients in more care settings.

Advancing Public Reporting

As required by law, CMS will post on its website the names of individual providers and group practices that are successful electronic prescribers. We recommend that CMS also report on eligible providers who chose not to participate in the program.

Improved Data Submission Options

In 2009, the reporting mechanism for e-prescribing was limited to claims-based reporting. For 2010, CMS proposes that registry and EHR-based reporting also be made available. The EHR reporting mechanism will only be available if its testing is finalized in time. We strongly support CMS' proposal to make EHR reporting mechanisms available to participating clinicians. As proposed under PQRI, we encourage CMS to decrease reliance on claims-based reporting. This dynamic will encourage greater clinician use of EHRs to improve patient care.

On behalf of the millions of Americans represented by the undersigned organizations, thank you for your efforts and your responsiveness to our comments. If you have any questions, please contact either of the Disclosure Project's co-chairs, Peter Lee, Executive Director, National Health Policy at the Pacific Business Group on Health, or Debra Ness, President of the National Partnership for Women & Families.

Sincerely,

AARP
AFL-CIO
American Benefits Council
American Hospice Foundation
Bridges To Excellence
Childbirth Connection
Consumers CHECKBOOK
Consumers Union
Hanover Area Health Care Alliance
HealthCare 21 Business Coalition
Health Policy Corporation of Iowa
Iowa Health Buyers Alliance
Mercer
Mid-Atlantic Business Group on Health
National Alliance for Caregiving
National Business Coalition on Health
National Partnership for Women & Families

New Jersey Health Care Quality Institute
New York Business Group on Health
Pacific Business Group on Health
Service Employees International Union
St. Louis Area Business Health Coalition
The Alliance
U.S. PIRG (Public Interest Research Group)