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

August 24, 2010

Donald Berwick, MD, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

File code: CMS-1503-P

RE: CMS Proposed 2011 Physician Fee Schedule
Comments from National Consumer, Labor, and Employer Organizations

Dear Dr. Berwick,

The 24 undersigned organizations representing consumer, labor, and employer interests are submitting these comments regarding the proposed 2011 Physician Fee Schedule.

The Patient Protection and Affordable Care Act moves us closer to a health care system that changes physician payment to reward value. This is an integral component to the reform. While we appreciate CMS moving swiftly to implement Affordable Care Act provisions for physicians, we believe you must be bolder in your actions. For too long, Medicare payment reform has been a slow moving process, at the expense of patients and taxpayers. The enactment of the Affordable Care Act offers an opportunity to be innovative and forward-thinking in making changes to provider payment. In particular, CMS must:

- Hasten the development of a strong foundation for value-based purchasing, effective measurement, data collection, and reporting.
- Foster physician use of health information technology that includes decision support and collects the performance information needed for quality improvement, public reporting and payment.
- Assess the impact of changes in public payment strategies on the entire system to avoid inappropriate adverse consequences (e.g., cost-shifting).
- Ensure appropriate valuing of services and use tools to monitor and manage cost growth.
- Realign payment incentives to drive better value and quality while also maintaining budget neutrality.

Our comments are organized into two general sections. In the main body of our comments we respond to particular issues and questions raised in the proposed rule and focus on the Physician Resource Use Measurement & Reporting Program, Physician Quality Reporting Initiative, and Electronic Prescribing Incentive Program. In the Appendix, we include two areas that are not in the proposed rule but are fundamentally important to address in this new era of health reform, the Resource-Based Relative Value Scale Payment System and Payment Incentives, as they serve as the foundation for revolutionizing physician payment.

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Validating RVUs of Potentially Misvalued Codes (II.C.2.c)

The validation of resource values for physician time and intensity should be based upon data from physician practices that perform efficiently. CMS should not be paying all physicians at rates that reflect inefficient care. In the Appendix we provide additional recommendations for addressing misvaluing of codes.

Physician Resource Use Measurement & Reporting Program (Section V.B.)

CMS, in accordance with the Affordable Care Act, will base the Value-based Payment Modifier, in part, on the Physician Resource Use Measurement & Reporting Program (RUR). Making certain that the RUR program reflects robust measures and produces meaningful results will be critical to ensuring that the Value-based Payment Modifier (which goes into effect in 2015) drives Medicare toward significantly improving the value and quality of care. Below are recommendations on the areas CMS requested comments.

- *Cost Measures:* We support CMS using per capita cost instead of episode-specific cost information next year. This population-based analysis makes sense for populations with chronic illness. Following that, we expect CMS will incorporate results from the Medicare specific episode grouper, which has to be developed before 2012.
- *Quality measures:* The measures from the Generating Medicare Physician Quality Performance Measurement Result (GEM) project have been in use for nearly a decade and represent basic standards of care. CMS needs to adopt a more robust and challenging set of measures for the value-based payment modifier.
- *Risk adjustment:* We agree that clinical process measures (including GEM measures) should not be risk-adjusted and support the use of Hierarchical Condition Categories (HCC) for cost data. NCQA has found HCC to perform as well or better than other more sophisticated risk adjustment models.
- *Sample sizes:* We recommend RUR use the reliability threshold of 0.70 in lieu of, or in conjunction with, a minimum case size for quality measures. The minimum case size for reliable reporting varies considerably by measure. For example, 30 cases is insufficient for certain measures (e.g., breast cancer screening) and overstates samples needed for other measures (e.g., arthritis DMARD). Also, minimum case size rules vary for individual physicians and practice sites.
- *Peer groups:* We vigorously oppose only comparing physicians in the same specialties. Primary care physicians or other specialists may practice more efficiently for patients with a given condition. This possibility should always be assessed. CMS, as a result, should include primary care physicians and relevant specialists in the reference group.
- *Attribution:* We believe that different attribution methods should be used for cost and quality measures. We support CMS' proposal to use "plurality-minimum" for cost metrics. For attribution of quality, we recommend plurality of E&M visits for single PCP attribution and minimum of 1 E&M visit for eligible specialists.

Medicare Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan (V.Q.)

We strongly support CMS requiring baseline assessments for depression screening and functional status in the first annual wellness visit. Besides the real-time ability to improve patient care, such assessments can be used to track health outcomes and performance over time. We think CMS should plan for using these outcomes in performance measurement programs, such as requiring longitudinal assessments and specific surveys to foster comparability.

We also support CMS removing financial barriers to patients accessing this preventive service. We ask CMS to consider how best to monitor and mitigate the associated risk of overuse of high cost screening and imaging tests.

Incentive Payment Program for Primary Care Services (V.S.1.)

We strongly support the implementation of a 10% increase in payment for physicians who provide primary care services, as required under the Affordable Care Act. This is an immediately practical, though incomplete, remedy to the continuing undervaluing of primary care.

Physician Quality Reporting Initiative (Section VI.F.1)

The Physician Quality Reporting Initiative (PQRI) has been in existence since 2007 but remains quite rudimentary. Rather than further diluting its requirements to "lessen the burden on eligible professionals (EPs) to qualify for incentive payments", CMS must strengthen the program. Below we provide recommendations for achieving a more robust program. We believe PQRI should transition to rewarding performance, not just reporting. Changes made now need to lay the groundwork for moving toward this goal.

Improve the current set of measures

CMS must implement more meaningful and impactful measures of care in PQRI. This can be achieved by removing measures that do not provide value and adding ones that do. Recognizing this will be a phased process due to current gaps in available measures, we recommend that CMS begin this process through the following actions:

- Require eligible providers to conduct patient experience surveys if there is a NQF endorsed survey available for that provider. For those that participate in a Maintenance of Certification (MOC) program, this requirement could be waived if the MOC program already includes patient experience surveys. We strongly urge that CMS move toward requiring the collection of patient experience surveys for all providers, in addition to other core clinical measures.
- Remove measures that "document" the presence of evaluation, assessment, and counseling. Documentation measures do not assess the quality of care provided and are often not evidence-based. There is no relationship between such measures and patient outcomes.[1]
- Add the five functional status measures and four care transition measures listed in the proposed rule to PQRI.

[1]Mark R. Chassin, M.D., M.P.P., M.P.H., Jerod M. Loeb, Ph.D., Stephen P. Schmaltz, Ph.D., and Robert M. Wachter, M.D. Accountability Measures, Using Measure to Promote Quality Improvement, New England Journal of Medicine, June 2010. <http://healthcarereform.nejm.org/?p=3580 >

- Consider adding measures from NQF's Ambulatory Care Measures Using Clinically Enriched Administrative Data that are appropriate for the Medicare population.
- Develop measures that will fill gaps in the measure dashboard and adhere to key criteria for robust measures.

Increase the number of required measures to create a comprehensive picture of the quality of care

We do not believe that reporting on only three or fewer measures to qualify for bonus payments is adequate. CMS must move beyond this requirement that has been in place since 2007. We support a requirement for larger group practices to report on a total of 26 quality measures in four measure groups: coronary artery disease, diabetes, heart failure, and preventive care services. We believe CMS should also assign sets of measures for individual and small group participants for high-volume conditions, based on the services provided to their patient population. And to create consistency and comparison across all participants (individual, smaller group, and larger group), CMS should assign a core set of measures that applies across eligible professions, such as patient experience and health status.

Strengthen reporting requirements for clinicians

Below are additional recommendations on improving the quality of the PQRI program:

- Require EPs to stratify measures by patient race, ethnicity, preferred language, and gender in order to measure and address disparities.
- Construct composites for the current measure clusters. These composites of process measures should be scored on an all-or-none basis.
- Use the reliability threshold of 0.70 in lieu of, or in conjunction with, a minimum sample size. The minimum case size for reliable reporting varies considerably by measure and for individual physicians and practice groups. Thus, reported results are more appropriate and accurate. We also make this same recommendation for the Physician Resource Use Measurement & Reporting Program.
- Increase the sample size for larger group practices to support reporting on individual clinicians. Reporting on individual clinicians will foster quality improvement and support consumer decision-making. Again, we recommend using the reliability threshold of 0.70 in lieu of, or in conjunction with, a minimum sample size. For example, the California Physician Performance Initiative established the sample size threshold as the sample size for which 90 percent of physicians had at least 70 percent reliability.[2]
- Maintain a threshold of 80% of Medicare Part B patients for claims-based reporting. Decreasing the threshold to 50% jeopardizes reliability and eventual public reporting of performance.

[2] California Physician Performance Initiative. Methodology for Physician Performance Scoring, Cycle 4. June 2010. http://www.cchri.org/programs/documents/FINALMethods_Document_Cycle4_Final6_10_2010.pdf

Focus on registry and electronic health records reporting mechanisms

We support CMS' efforts to promote the use of registries and EHRs for clinical quality measures. Additionally, we support the Maintenance of Certification (MOC) program's 0.5% bonus payment add-on for PQRI, as required by the Affordable Care Act, which includes a registry component. MOC programs require physician participation in lifelong learning and continuous professional development and include, among other things, assessment of physician practice performance and improvement. In addition to requiring physicians to act on the results, we are very pleased that the Part IV practice assessment includes a survey of patient experience and greatly appreciate CMS' interest in patients as an important source of information to improve quality.

Aligning with meaningful use

The Affordable Care Act requires the Secretary, by January 2012, to develop a plan to integrate reporting on PQRI measures with the "meaningful use measures". To align PQRI and the meaningful use program, CMS proposes "to include many ARRA core clinical quality measures in the PQRI program to demonstrate meaningful use of EHR and quality of care furnished to individuals." We support alignment of the programs and in particular look forward to when both measures from PQRI and meaningful use will be publicly reported via Physician Compare.

Public reporting of performance

We again urge CMS to publicly report information on individual providers and group practices that qualify for a PQRI incentive payment. Likewise, we recommend CMS make available information on whether a physician received the additional bonus for successfully meeting MOC program requirements.

The Affordable Care Act requires CMS to publicly report PQRI data through Physician Compare by January 2013. We wholeheartedly support moving in this direction and believe measures from other initiatives, such as meaningful use and the Physician Resource Use Measurement & Reporting Program, should be included as well. Public reporting promotes accountability, stimulates improvement, and provides much needed information for beneficiaries to support their decisions.

The CMS plan for displaying performance information should be designed to support consumers' information and decision-making needs. This means it should:

- Report information at the individual clinician level, not just the practice group level, whenever feasible. Patients need information on individual provider performance. Physicians may operate as part of a team, but patients often will still select individual physicians.
- Facilitate comparisons across relevant providers and not allow variations across providers to be unduly obscured. For many consumers, measurements with misclassification error of up to 20% may be preferable to no measurements.[3]
- Provide a comprehensive picture of the care a clinician delivers across conditions**.** Patients need to know how physicians care for all their patients.

[3] Matthew M. Davis, Judith H. Hibbard, Arnold Milstein. Consumer Tolerance for Inaccuracy in Physician Performance Ratings: One Size Fits None. Center for Studying Health System Change, March 2007. <http://www.hschange.com/CONTENT/921/>

In addition, CMS must make data available at a granular level so it can be combined with commercial payer data to develop a more comprehensive assessment of physician performance across public and private sectors. Many regional reporting initiatives would like to rely on all-payer data to populate their provider selection tools; access to the CMS data would significantly reduce the imposition of additional reporting requirements on providers.

Electronic Prescribing Incentive Program (Section VI.2)

The Electronic Prescribing Incentive Program sets the bar too low for determining "successful electronic prescribers", a concern that we have also voiced in previous years. We recommend that CMS should, at a minimum, require eligible professionals to electronically transmit more than 40% of written prescriptions, which is in line with the meaningful use incentive program. We do however applaud CMS' plans to improve transparency of patient care by making the names of successful electronic prescribers available on Physician Compare.

Closing

On behalf of the millions of Americans represented by the undersigned organizations, thank you for your efforts to improve how Medicare pays physicians and ultimately patient care. As you seek to transform Medicare, now more than ever, the changes made will have an impact on costs in the private sector. We look forward to partnering with you on transforming the health care system. If you have any questions, please contact either of the Disclosure Project's co-chairs, Debra Ness, President of the National Partnership for Women & Families, or David Lansky, President & CEO of the Pacific Business Group on Health.

Sincerely,

AARP
AFL-CIO
American Benefits Council
American Hospice Foundation
Childbirth Connection
Consumers' CHECKBOOK/Center for the Study of Services
Consumers Union
Employers' Coalition on Health
Employers' Health Coalition
Health Action Council Ohio
Health Care Incentives Improvement Institute
HealthCare 21 Business Coalition
Health Policy Corporation of Iowa
HEREIU Welfare Fund
Iowa Health Buyers Alliance
Mid-Atlantic Business Group on Health
Midwest Business Group on Health
National Business Coalition on Health
National Partnership for Women & Families
National Retail Federation
New Jersey Health Care Quality Institute
New York Business Group on Health
Pacific Business Group on Health
The Leapfrog Group

APPENDIX

Payment reform will not reach its full potential if it continues to be based on a system that is inherently flawed. CMS must improve the building blocks and mechanisms of current, as well as potentially future payment to ensure we appropriately value services and have the right tools to monitor and manage cost growth.

Resource-Based Relative Value Scale Payment System

Current Medicare payment policies encourage service volume and are indifferent to quality. Over coming years, CMS will test and adopt new and better ways of paying for care that promote better value for beneficiaries. However, many of the payment changes will be layered on a fundamentally faulty Resource-Based Relative Value Scale (RBRVS). Additionally, the move to other models will take time so the significant reliance on RBRVS will continue. For these reasons, we believe CMS must improve the RBRVS while it also seeks to implement new models of payment.

Creating a Separate Group Panel of Experts to Review Relative Value Units

Currently, CMS' 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 represent over two dozen medical specialties. 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. 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).

We agree with MedPAC's (2006) recommendation that CMS develop a new, independent panel of experts to advise it on RVUs. We also support MedPAC's suggestion that the panel "include members who do not directly benefit from changes to Medicare's payment rates." Furthermore, we believe the majority of the panel should include those who are paying for health care (e.g., consumers and purchasers) and subject matter experts that do not have a vested interest (e.g., medical economists, technology experts). We were extremely disappointed that CMS decided to put this recommendation on hold in the final rule for the 2010 Physician Fee Schedule.

Payments Should Reflect Societal Values, Not Just Provider Costs

We also believe the scope of this panel should go beyond the traditional definition of value of provider costs (e.g., physician resources) being the sole factor for payment and consider a much broader framework for value. 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. The new 'value' factor should consider such things like policy priorities, patient preferences, and Medicare's fiscal sustainability. When physician resources are considered, it should be based on the most efficient practices.

Finally, the Patient Protection and Affordable Care Act calls for the Secretary of Health and Human Services to develop a process for validating relative values. We believe there is a role for the above recommendations in that process. By implementing these recommendations, CMS would make great strides in achieving a patient-centered health care system that delivers appropriate care.

Undervaluation of primary care services

Primary care providers are vital to caring for older Americans and providing care coordination and preventive services. The undervaluation of primary care has had severe consequences on the supply of primary care physicians. To address the imbalance in payments between primary care and other specialties, we support the increase in payments that were outlined in the Affordable Care Act. We also support the change CMS made this year for eliminating consultative codes and using current E/M codes. However, these are only temporary fixes and there is a great need for a longer term solution. It is critical that Medicare begin to reduce the gap between payment for specialists and primary care. Improving the process of valuing services by creating an independent expert advisory panel and including societal values, as discussed previously, creates a system that is fair to all physicians as well as beneficiaries.

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 must realign payment incentives to drive better value and quality while also maintaining budget neutrality.

The Affordable Care Act calls for the implementation of specific payment programs (e.g., accountable care organizations, medical homes, etc.) as well as a new unit, the Center for Medicare and Medicaid Innovation, to test innovative payment models. We wholeheartedly support the rapid testing of innovative payment methods and quickly implementing successful programs. Moreover, we believe payment incentives collectively should:

- Tie a substantial portion of CMS payment to performance, and increase that portion over time.
- Reward a combination of achievement and improvement.
- Drive rapid re-engineering of care delivery.
- Encourage the integration and delivery of services for the highest cost and highest risk patients.
- Recognize that savings may apply across sectors. For instance, CMS should consider how physician services may reduce expenditures for hospitals.
- Promote speedy alignment and harmonization of payments among Medicare, Medicaid, and private sector payers.
- Incorporate strong patient protections including transparency of provider financial incentives, choice and adequacy of access to providers, and an effective and accessible appeals process.

As new payment programs and other payment changes (e.g., valuing of services, market basket updates, etc.) are implemented, we believe it is critical for CMS to assess the impact of changes in public payment strategies on the entire system. Payment reform efforts should seek to minimize the negative impacts (e.g., increased cost-shifting) of payment decisions made by one sector on the other and send consistent market signals to reward higher value.