

Consumer-Purchaser

DISCLOSURE PROJECT

Better information. Better decisions. Better health.



September 6, 2013

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

RE: CMS 1600-P; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Medicare Part B for CY 2014

Dear Ms. Tavenner:

The 27 undersigned organizations are part of a collaboration of leading consumer, labor, and employer organizations committed to improving quality and affordability of health care through the use of performance information to guide consumer choice, payment, and quality improvement. We appreciate the opportunity to comment on the Payment Policies under the Physician Fee Schedule (PFS) and other Revisions to Part B for CY 2014 Proposed Rule.

The proposed rule outlines changes to several programs, including the Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (VBM), the Medicare Electronic Health Record (EHR) Incentive Program, and the Physician Compare Website. We greatly appreciate that the proposed rules reflect CMS's concerted efforts to be responsive to the needs of consumers and purchasers. In particular, we are pleased with: the inclusion of patient experience measures (CG-CAHPS) and the additional sources of data, such as Electronic Health Records and Clinical Data Registries; the focus on improving care coordination and care transitions; and, the identification of problems with the Resource-Based Relative Value Scale. In addition, we commend CMS for its effort to continue strengthening existing programs and hope that the improvements will support reformed payment systems that reward greater value rather than just volume of services provided.

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

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

Finally, we believe that CMS should:

- 1) Use a parsimonious core set of high impact measures that will drive the achievement of HHS' Three Aims.
- 2) Identify the ideal dashboard of measures and step up the pace for completing the dashboard within a reasonable period of time (2-3 years).
- 3) Align select program activities, including measurement, payment, and public reporting, within Medicare and with other public and private payers.
- 4) Encourage both individual and shared accountability of providers for safety, quality, and cost of care.

In the Appendix, we provide specific suggestions on programs in the order in which they appear in the proposed rule. 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

The Alliance

American Benefits Council

American Federation of State, County & Municipal Employees

American Hospice Foundation

Business Healthcare Group

Caregiver Action Network

Center for Medical Consumers

Childbirth Connection

Dallas-Fort Worth Business Group on Health

Equity Healthcare

Health Care Incentives Improvement Institute

Health Policy Corporation of Iowa

Iowa Health Buyer's Alliance

Massachusetts Group Insurance Commission

National Business Coalition on Health

National Council of Jewish Women

National Partnership for Women & Families

National Retail Federation

New Jersey Health Care Quality Institute

Pacific Business Group on Health

Puget Sound Health Alliance

PULSE of America

Texas Business Group on Health

Virginia Business Coalition on Health

Wyoming Business Coalition on Health

Well Spouse Association

APPENDIX

Non-Quality Related Provisions of the 2014 MPFS Proposed Rule

POTENTIALLY MISVALUED SERVICES

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

The CY 2014 PE RVUs are based entirely on the Physician Practice Information Survey (PPIS) data, which we believe is based on an unreliable methodology. We also are concerned that it is conducted and paid for by the American Medical Association (AMA), which, as a physician membership organization, has a direct conflict of interest in the survey results. **We recommend that the PPIS survey be conducted by an independent entity that is not directly tied to the physician community and that the PPIS be revised with a more rigorous methodology.** CMS has begun gathering data independently of the AMA and we applaud this move. We encourage CMS to devote resources to expand this data collection with the goal of improving the accuracy of the practice and intensity of time expenses.

We agree with the spirit of CMS's proposal to limit the PFS payment to the total payment that Medicare would make to the practitioner and the facility when the service is furnished in a hospital outpatient department or Ambulatory Surgery Center. **We believe that CMS should pay physicians at the same rate for the same service, regardless of the site where the service is provided.** We would carry the concept one step further: the payment for any service that can be safely provided in a physician's office should be based on the amount that is paid in that setting to discourage unnecessary use of more expensive facilities.

MEDICARE TELEHEALTH SERVICES

Billing and Payment for Telehealth Services

CMS is proposing to modify its regulations regarding originating sites to define rural Health Professional Shortage Areas (HPSAs) as those located in rural census tracts identified by the Office of Rural Health Policy (ORHP). CMS asserts that defining "rural" to include geographic areas located in rural census tracts within metropolitan statistical areas (MSAs) would allow for the appropriate inclusion of additional HPSAs as areas for telehealth originating sites.

- We support CMS' proposal to expand access to health care services for Medicare beneficiaries located in rural areas that do not fit within the current definition in order to permit telehealth services in these shortage areas.

Other Additions to the List of Medicare Telehealth Services

CMS is proposing to add two CPT codes for transitional care management services to the list of Medicare telehealth services for which PAs, physicians and others may bill and to revise its regulations to include transitional care management (TCM) services as Medicare telehealth services. These services are provided to a patient whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions from an inpatient hospital

setting (including acute hospital, rehabilitation hospital, and long term acute care hospital), partial hospitalization, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting (home, domiciliary, rest home, or assisted living).

- We support including transitional care management services in the list of Medicare telehealth services because this change is tied to ongoing efforts by CMS to ensure reduced readmissions and better care coordination. CMS should allow the face-to-face visit component of the two CPT codes to be delivered via telehealth.

COMPLEX CHRONIC CARE MANAGEMENT

CMS is proposing an additional payment for complex care management services furnished to patients with multiple complex chronic conditions by establishing two new separately payable G-codes for use in 2015. The requirements proposed by CMS include the development of a plan of care, coordination with home and community based providers, and multiple methods of non-face-to-face communication. In addition, the beneficiary must have had an annual wellness visit in the preceding 12 months furnished by the same practitioner billing for complex care management.

Complex health care needs account for a high percentage of annual medical expenditures.¹ We believe that care coordination is an integral part of improving patient care and, if done effectively, can have an impact on reducing costs. While we support CMS' efforts to improve care coordination by promoting complex care management, **we do not believe CMS can achieve the goal of improving care coordination solely with the creation of 2 new G-codes.** The new codes center on certifying that a physician practice has the capacity to perform basic care coordination activities, rather than paying for the actual coordination. The creation of new codes can serve as an interim step until more providers are participating in global payment models. We encourage CMS to strengthen standards in the area of quality measures and patient engagement and to create operational definitions for activities that it lists in the scope of complex chronic care management services - such as the integration of new information into the care plan.

Ultimately, **we believe it is more effective to pay clinicians based on their actual delivery of high value care.** Complex care management activities should be patient-centered and designed to improve quality of life, patient satisfaction, and reduce hospital readmissions. CMS should continue to focus its efforts on designing and encouraging participation in payment systems such as medical homes and accountable care organizations (ACOs). **Furthermore, care coordination should be measured and reimbursed based on improved patient outcomes rather than certification of basic processes and standards,** such as the use of certified EHR technology and the development of a plan of care. Furthermore, patients should be asked to report whether they perceived their care to have been appropriately coordinated among the various providers who serve them. Ideally, both public and private payers will move to a global payment approach covering ambulatory care, emergency treatment and hospital care that provides incentives for primary care practices, hospitals and integrated delivery systems to implement care management programs that incorporate adequate safeguards against stinting on care or shunning high-cost patients.

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

We encourage CMS to continue its commitment to improve payment for, and encourage long-term investment in, care management services.

Quality Provisions of the 2014 MPFS Proposed Rule

PHYSICIAN COMPARE WEBSITE

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

The Affordable Care Act (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 that the website be populated with information on patient health outcomes, functional status, care coordination and transitions, resource use, efficiency, patient experience, and patient, caregiver and family engagement. CMS describes the information that is currently publicly available, such as whether the provider accepts Medicare assignment, his or her hospital affiliations, secondary specialty, etc. In addition, information as to whether the provider participates in PQRS is disclosed. While this information may be useful, it is far from sufficient to help beneficiaries make informed choices.

The first step of the planned phased approach to reporting performance data will be made public in CY 2014, with the publication of limited data on physician groups (e.g., on diabetes, coronary artery disease and G-CAHPS), rather than on individual physicians. Publicly available performance information is central to value-based health care. Therefore, although we appreciate the technical challenges of populating Physician Compare with performance information, CMS should work to meet the statutory requirements as quickly as possible to foster more rapid improvement, accountability and enable consumers to make informed decisions. **We urge CMS to begin posting the information that it has already gathered.**

While the primary source of administrative information on Physician Compare is the Provider Enrollment, Chain, and Ownership System (PECOS), CMS now incorporates Medicare claims information to verify the information in PECOS to ensure the most current and accurate information. **We are encouraged that CMS is now incorporating claims data into Physician Compare** and hope that such efforts to improve the accuracy of information will continue. We know that CMS shares our interest in ensuring that data on Physician Compare are accurate and timely so that the public and providers have full confidence in the site. Therefore, **CMS should put in place routine audits of the data to ensure its accuracy and timeliness.**

Public Reporting of Individual Data

CMS proposes to publicly report performance data collected for the CY2014 PQRS via claims, EHR or registry from individual EPs “as early as” CY 2015. **We urge CMS to speed up reporting of performance at the individual physician level as quickly as feasible.** While we understand there are methodological challenges in reporting individual-level information, we urge CMS to address these issues without delay. To the extent that individual information is not available via claims, we encourage CMS to use alternative data sources, such as information gathered from EHRs

and registries. 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.

We are very pleased to see that CMS is proposing to add to Physician Compare many high value measures such as those for diabetes control, medication reconciliation, preventive care and screening for depression and cancer, as well as the cardiovascular prevention measures group in support of the Million Hearts Initiative, for public reporting.

CMS is also seeking comments on publicly reporting patient experience performance data for individual physicians starting with data collected for CY 2015. **We enthusiastically support publicly reporting patient experience information, especially for the individual physician.** Consumers find information from other patients helpful and the physician is the most salient unit of analysis for them. Furthermore, there is a body of evidence demonstrating that improving patient experience is directly linked to improvements in health outcomes, so public reporting also promotes quality improvement.

CMS is also planning to expand public reporting of individual performance data on measures that have been developed and collected by approved specialty societies, as well as data collected via the new qualified clinical data registry option proposed under the PQRS. We encourage CMS to move away from measures that are developed solely by specialties and to select measures that have been endorsed by NQF. These measures should be salient to beneficiaries and provide a useful picture of a physician's performance. In particular, composite measures of quality for specific conditions should be used to convey a meaningful "picture" to consumers. Measures that are in use and have proven to meet the needs of consumers and purchasers, although not yet endorsed by NQF, should be considered as well.

Public Reporting of Group Practice Data

For 2014, CMS proposes to expand public reporting to all measures collected through the GPRO web interface for groups of all sizes participating in the 2014 PQRS GPRO and for Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program. The data reported in 2014 would include performance rates for measures included in the 2014 PQRS GPRO web interface that meet the minimum sample size of 20 patients, and that prove to be statistically valid and reliable.

- We strongly support CMS' proposal to expand public reporting on measures to groups of all sizes.
- We support CMS' addition of many high-value control and screening measures to the list of publicly reported measure for groups, e.g., Diabetes: Hemoglobin A1c Poor Control, CAD-Lipid Control, and Medication Reconciliation.
- We suggest increasing the sample size from 20 patients for larger group practices to support reporting on individual clinicians. Using a reliability threshold of 0.70 is a preferred alternative to an arbitrary minimum sample size and should be measure-specific.

In 2013, CMS also began to collect patient experience survey data for group practices participating in the GPRO and ACOs using the CG-CAHPS survey. CMS intends to publicly report these

measures on Physician Compare in 2014 for data collected for CY 2013 for ACOs and group practices with 100 or more eligible professionals (EPs) reporting through the GPRO web interface.

- We strongly support use of patient-reported experience measures as a key dimension of performance accountability and support use of the CG-CAHPS. We further support reporting this information on Physician Compare in addition to use in PQRS and the Value Based Modifier. We recommend that CMS explore ways to begin collecting CG-CAHPS data from a mixture of Medicare and commercial patients to encourage public-private performance accountability alignment.

CMS will administer and fund the collection of CG-CAHPS data on a sample of the group's patients. CMS also proposes to publicly report CY 2014 data for groups of 25 or more EPs that voluntarily choose to report CG-CAHPS. However, CMS will not fund the surveys for these groups.

- In order to encourage greater utilization of CG-CAHPS, CMS should strongly consider funding the collection of CG-CAHPS data for groups of 25 or more EPs. In the interim, CMS should explore ways to facilitate small practices' participation in CG-CAHPS that are economically feasible—perhaps in conjunction with other initiatives, such as Maintenance of Certification (MOC). Finding a sustainable funding source is a significant challenge to collecting patient-reported experience information. Limiting funding only to larger groups is short-sighted and will discourage smaller groups from participating in the CG-CAHPS Survey. As noted, we also encourage CMS to begin collect patient experience survey data for individual physicians. Alternatives to the more costly, traditional paper-based survey method that take advantage of electronic media that are becoming increasingly accessible to the public should be further investigated.

Other Physician Compare Comments

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 that provide minimal value to consumers in comparing providers, or for assuring that physicians are providing high quality care. 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.

CMS also seeks comment on publicly reporting participation by individual professionals on initiatives such as Choosing Wisely. It is not clear to us how a physician would demonstrate such participation, particularly given the absence of metrics that either measure adherence to the recommendations (many of which are very narrowly drawn) or shared decision making, which undergirds the Choosing Wisely initiative. **We advise CMS to publish information on those programs for which there is a robust set of measures as well as explicit ways to indicate accomplishment or compliance**, such as Meaningful Use or board certification. We are concerned about needlessly confusing consumers with programs with which they are not familiar and for which clear indicators of successful participation are lacking.

PHYSICIAN QUALITY REPORTING SYSTEM

Proposed Changes to Individual Reporting Criteria for the 2014 PQRS Incentive

For individual participation in PQRS, CMS proposes to increase the number of measures that must be reported from three to nine measures. The measures must cover at least three of the 6 National Quality Strategy domains.

We support the CMS proposal to require physicians and other clinicians to report more measures to create a better picture of the quality of care they provide. Since 2007, EPs only needed to report on three measures of their choice. We consider this requirement inadequate and a fundamental flaw in the program, since clinicians rarely perform consistently across the spectrum of patients and conditions they encounter.

While we generally support the increased number of measures that physicians must report from three to nine, a larger problem persists: permitting EPs to choose a subset of measures enables cherry-picking.

Increasing the number of measures alone will do little to improve PQRS if CMS does not improve the quality of the measures themselves. We are encouraged that CMS has begun to develop a core set of high-value measures that would be required for all EPs in a given specialty area. We believe that many of the recommended adult core clinical quality measures (CQMs) such as functional status assessment for complex chronic conditions, use of imaging studies for low back pain, use of high risk medication, and other screening measures are of high value. We also support the addition of pediatric core CQMs such as weight assessment and counseling, use of appropriate medications for asthma, and screening for depression and dental decay.

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. We consider the following types of measures to be of low value:

- expectations/standards of care measures;
- measures of basic competencies;
- “check-the-box” measure that simply assesses whether the clinician completed an assessment;
- measures of prescriptions written rather than prescriptions filled; and
- documentation measures.

While CMS has added outcome measures, it should add measures that fill current gaps, such as appropriateness and 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 they conducted a functional health assessment, CMS should require reporting of the change in health status from one period to another. We prefer that CMS use NQF-endorsed measures in its programs. However, in certain cases, CMS may decide to use non-endorsed measures. We support

the inclusion of some measures to fill measurement gaps identified by CMS; however, we strongly recommend that those measures be submitted for NQF endorsement.

Patient Reporting Threshold

In conjunction with its interest in increasing the number of measures reported, CMS also proposes to lower the percentage of applicable patients a physician must report on from 80% to 50% in order to be considered a “satisfactory reporter.”

Regarding the patient reporting threshold, **we strongly urge CMS to consider raising the threshold to 100% of Medicare Part B patients for claims-based reporting.** The 50% threshold jeopardizes reliability and public reporting of performance. CMS should raise its standards for PQRS in recognition of EPs who have adopted electronic health records. Those who have adopted EHRs should be able to report data based on all their patients who meet denominator criteria, and CMS should tighten its requirements accordingly. By eliminating sampling, CMS would ensure that reporting is unbiased and, in some areas at least, sufficiently robust to enable accurate reporting at the individual clinician level.

PQRS Measures and Measures Groups

For 2014, CMS proposes to add 47 new individual measures and three measures groups to fill existing measure gaps, and to retire a number of claims-based measures to encourage reporting via registry and EHR-based reporting mechanisms.

- As noted, we fully support CMS’s efforts to fill existing measure gaps. We believe a roadmap on how to fill in the gaps in measures would be useful to clearly identify priority areas to allow all parties to make the most effective use of resources. For example, CMS should adopt an aggressive timeline to integrate meaningful specialty care measures, including patient-reported outcomes.
- We also support CMS’s intention to encourage reporting via registry and EHR-based reporting mechanisms. While claims-based reporting is the most widely used PQRS reporting mechanism, CMS has found that it is subject to coding omissions and errors that lead to reporting inaccuracies. Therefore, alternative data sources would be beneficial. Registry and EHR users are at an advantage, as they are able to analyze their quality data and ensure their accuracy.

For 2014, CMS proposes to increase the minimum number of measures that may be reported in a measures group from four to six. In doing so, it will add additional measures to measures groups that previously contained fewer than six measures.

- We believe that CMS should consider raising the minimum to nine measures, which would be consistent with the proposed reporting requirement for individual measures. CMS has expressed concerns about fairness because an EP must report *all* measures contained in a measures group versus being able to report on any nine measures of their choosing when reporting measures individually. We believe that in order to address these concerns, **CMS should instead require physicians who are reporting individually to report on all**

measures contained in the measure group. Allowing a choice of measures permits “cherry-picking” and may distort the actual picture of a physician’s practice.

PQRS Qualified Clinical Data Registries

CMS proposes to add a new clinical data registry option, permitting physicians and other PQRS-eligible professionals to report quality measures used by a clinical data registry instead of those on the PQRS measures list.

Registry-based measures can be important tools for research, quality improvement and EP accountability by using the measures for public reporting and payment programs. We suggest several criteria to guide the use of registries in federally-sponsored accountability programs. We strongly believe program sponsors of accountability programs (e.g., CMS and other purchasers/payers, and professional credentialing/certifying entities) should retain responsibility for determining the qualifying criteria to protect against the inherent conflict of interest of those registries that are sponsored by representatives of participants in those programs, we therefore support CMS’ plan to certify registries.

We support that, under the proposed qualified registry option, at least one of the measures must be an outcome measure; however, we encourage CMS to move toward requiring reporting on more than one outcome measure. We also strongly support the proposal that EPs may also report on all patients, regardless of payer source. We question why CMS categorizes reporting for clinical conditions through the Qualified Clinical Data Registries (QCDR) as individual measure reporting rather than as measure group reporting. Registry data are generally condition- or procedure-specific, so it makes sense to define them into measure group. Moreover, we appreciate that quality improvement frame that CMS aims to maximize through the QCDR pathway is best served through the collection of data that provides the physician with detailed, actionable information on many facets of his or her clinical practice which, in turn, requires considerable manual effort on the part of the physician to abstract. Given this reality, and the unique QI frame of the QCDR pathway, we strongly suggest that CMS retain the option for QCDR participants to report on a sample of 20 relevant patients, subject to documented and verifiable record selection criteria to eliminate cherry-picking. We think that until EHRs have the flexibility to report the data elements needed by the QCDRs, the option of sampling will be essential for organizational and physician participation in them.

Accountability programs should not give credit (i.e. financial incentives) for participation alone, except as a temporary step in a staged process. Participation in meaningful quality improvement activities is the desired behavior and should be expected and recognized as part of this new pathway. For example, a possible staging scheme for reaching full accountability (payment and public reporting) might be as follows:

- Stage 1: Physicians and other providers get credit for participation if they 1) submit data on a substantial proportion of their patients to the registry and 2) if the registry provides data back to the provider that can be used for improvement and care management.
- Stage 2: Once the registry has sufficient data, it provides feedback on measures at the individual clinician, small practice group, and/or hospital levels against benchmarks. The registry could also permit EPs to publicly report their performance if they so choose.

- Stage 3: Registry publicly reports required performance measures at the individual clinician, small practice group, and hospital levels for all the relevant participants.

Requirements for a Qualified Clinical Data Registry

We support the proposed requirements for clinical data registries including the requirements for the registry to provide timely physician feedback as required by the authorizing legislation. However, we are concerned that specifying the periodicity of such feedback may inadvertently exclude participants such as the certifying boards and other entities that are not designed as longitudinal disease/patient tracking registries but focus specifically on measuring and enhancing individual physicians' clinical skills through immediate point-in-time performance feedback followed by a concentration on QI interventions. We encourage CMS to adopt a more flexible interpretation of "timely" that is consistent with the purpose of the registry and to vet sponsors' practices as part of the self-nomination process. We also support the criteria that the registry should have a plan to publicly report data about individual EPs. We believe that clinicians from a technical specialty, e.g., proceduralists, should not get credit for group performance. **To meet consumer and purchaser needs, registries should be required to report at the individual clinician level.**

Generally we believe that **at a minimum, qualified clinical data registries should meet the following requirements:**

- Governance by a multi-stakeholder board that includes meaningful participation by public representatives which include patients, consumers and purchasers.
- Demonstration of organizational stability, maturity and achievement (e.g., in existence for a minimum number of years, established infrastructure).
- Adequate penetration of potential participant population, e.g., X% of EPs already submitting data to the registry.
- Transparent as to purpose and sponsorship of registry, governance, size, data handling capabilities, success with QI, etc.
- Evidence of reasonable fees that are used only to cover the costs of maintaining the registry.
- Timely communication of results.

Qualified clinical data registries should not be limited to national registries operated by professional societies

Electronic Health Record (EHR) Incentive Program

Beginning with the 2014 reporting period, CMS proposes to allow EPs to submit CQM information using qualified clinical data registries only for those EPs who are beyond their first year of demonstrating meaningful use.

This requirement relies on EHR vendors to adopt the data and interoperability standards being developed by ONC/HHS. Additionally, registries should use standards for common data elements, such as LOINC codes for laboratory data and NCPDP standards for pharmacy data. Finally, **the denominator populations for registry-produced measures should include all clinically relevant patients under the provider's care, regardless of insurance status.**

Providers using an EHR that can transmit data electronically to the registry should be expected to submit data on all their patients.

Future of Use of the Claims-based Reporting Mechanism in PQRS

CMS seeks comment on whether it should eliminate the claims-based reporting mechanism beginning with the reporting period (calendar year 2017) for the 2019 PQRS payment adjustment.

- We support the elimination of the claims-based reporting option in CY 2017. By that time, more physicians participating in the PQRS program will have begun using alternative reporting modalities. We believe that by signaling its intent now, CMS will give physicians sufficient time to begin using alternative reporting. Eliminating claims-based reporting should spur more rapid adoption and meaningful use of EHRs.

Potential Future Changes

CMS is exploring ways to merge the feedback reports provided to participants in PQRS and for calculation of the Value-Based Modifier so that an EP would receive one, merged feedback report showing reporting data for PQRS and performance data for the VBM.

- To the extent that merging feedback reports will provide physicians with a readily understandable snapshot of performance and present the data in a manner that enables accurate interpretation, we support this proposal. We also encourage these feedback reports to provide physician-level feedback so that EPs know how they are performing compared to their peers within group practices.

Other Comments

CMS is proposing one more criterion for avoiding the 2016 payment adjustment than for the 2014 PQRS incentive with respect to claims-based reporting, but the other criteria would otherwise align.

- Permitting EPs to avoid the 2016 adjustment if they satisfy the reporting requirements for 2014 sets a low bar and allows EPs to maintain a basic level of reporting compliance based on measures that have yet to be fully improved. We support CMS' commitment to **increase the criteria for satisfactory reporting for the 2017 PQRS payment adjustment to be on par or more stringent than the criteria for satisfactory reporting** for the 2014 PQRS incentive.

Medicare Shared Savings Program

CMS is proposing to increase the scoring for the CG-CAHPS survey measure modules within the patient experience of care domain, so that the CAHPS survey measure modules would carry greater weight within the patient experience of care domain.

- We support increasing the weight of the CG CAHPS survey measure within the patient experience domain. Patient experience is a key piece of the Three Aims and including this measure also will align CMS's shared savings program.

VALUE-BASED PAYMENT MODIFIER

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 step in the direction of value-based physician payment.

We believe that the following principles should guide the program's continued 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.

We are concerned that participation in the value-based payment modifier (VBPM) remains tied to participation in PQRS. While we support streamlining programs, we have longstanding concerns with the PQRS program that we have shared in this and previous comment letters. **We continue to object to linking participation in the value-based payment modifier with participation in PQRS and urge CMS to consider alternative approaches.**

CMS proposes to lower the group size threshold from 100 or more eligible professionals to groups of 10 or more eligible professionals to determine applicability of the value-based payment modifier.

- We are encouraged that CMS intends to incorporate smaller group sizes into the VBPM. However, we are concerned with a potential unintended and undesirable consequence: because the planned quality-tiering will exempt smaller group practices (of between 10 and 99 EPs) from downward payment adjustments, most of the VBPM penalties will fall on the shoulders of primary care physicians, who tend to practice in larger groups, while a large percentage of specialty physicians, who tend to practice in smaller groups, will be exempted. **We therefore recommend that downward payment adjustments apply to all groups, regardless of size.**

CMS is further proposing to increase the downward adjustment under the value-based payment modifier from 1.0 percent in CY 2015 to 2.0 percent for CY 2016.

- **We believe that a 2.0 percent adjustment is not sufficient to incentivize physicians to improve quality.** Overtime, as CMS begins to adopt a more robust set of outcomes

measures, CMS should increase the proportion of physician payment to the Value Modifier, eventually reaching at least 10%.

CMS proposes that groups of 25 or more eligible professionals would be able to elect to have the patient experience measures collected through the PQRS CG-CAHPS survey for CY 2014 included in their value-based payment modifier for CY 2016.

- As noted above, we strongly support use of patient-reported experience measures as a key dimension of performance accountability and, as such, support use of CG-CAHPS metrics. However, because CMS will not fund the collection of CG-CAHPS for groups of fewer than 100 EPs, we are concerned that these smaller groups will not elect to have this important information included in their value-based payment modifier for CY 2016. We therefore reiterate our recommendation for CMS to reconsider its funding plans to support the collection of CG-CAHPS data for groups of 25 or more EPs.