Statement

of the

American Medical Association

to the

Centers for Medicare and Medicaid Services
of the Department of Health and Human Services

Re: Public Town Hall Meeting
2012 Physician Quality Reporting System
(Physician Quality Reporting)

February 25, 2011

25 Massachusetts Avenue, NW, Suite 600
Washington, DC 20001
Division of Legislative Counsel
202 789-7425

Statement

of the

American Medical Association

to the

Centers For Medicare And Medicaid Services

of the

Department of Health and Human Services

Re: Public Town Hall Meeting
2012 Physician Quality Reporting System
(Physician Quality Reporting)

February 25, 2011

The American Medical Association (AMA) appreciates the opportunity to present our views to the Centers for Medicare and Medicaid Services (CMS) concerning implementation of the 2012 Physicians Quality Reporting System (PQRS). CMS has solicited comments to questions posed at the February 9, 2011, Public Town Hall Meeting concerning the PQRS, and the AMA is happy to provide our views below.

PQRS Measure Work Timeline Process for Measure Developers

Measures Appropriate for Electronic Health Record Reporting

The AMA recommends the following Physician Consortium for Performance Improvement (PCPI)-developed measures for electronic health record (EHR) reporting for the 2012 PQRS:

1. Coronary Artery Disease: Blood Pressure Control. Electronic Specifications have been developed for this measure.

2. Coronary Artery Disease: Symptom Management. Electronic Specifications have been developed for this measure.

3. Hypertension: Blood Pressure Control. Electronic Specifications have been developed for this measure.

4. Endoscopy and Polyp Surveillance: Appropriate follow-up interval for normal colonoscopy in average risk patients.

The PCPI has already developed electronic specifications for three of the above four measures. These measures were submitted to CMS during the CMS 2012 call for measures. The AMA would like to highlight these as measures appropriate for EHR as a data source, and supports CMS' desire to move more measures forward for EHR reporting. Towards this end, we urge CMS to make resources available to re-tool quality measures for EHR capture, and test these new specifications prior to implementation.

2011 PQRS Measures Recommended for EHR Reporting in 2012

The following measures are currently in the 2011 PQRS, and the AMA recommends them for EHR Reporting in 2012. Electronic specifications have been developed for the following measures:

- #10: Stroke and Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports
- #12: Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
- #18: Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
- #19: Diabetic Retinopathy: Communication with the Physician Managing On-going Diabetes Care
- #71: Breast Cancer: Hormonal therapy for Stage IC – IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer
- #72: Colon Caner: Chemotherapy for Stage III Colon Cancer Patients
- #86: Hepatitis C: Antiviral Treatment Prescribed
- #89: Hepatitis C: Counseling Regarding Risk of Alcohol Consumption
- #102: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients
- #106: Major Depressive Disorder (MDD): Diagnostic Evaluation
- #107: Major Depressive Disorder (MDD): Suicide Risk Assessment
- #145: Radiology: Exposure Time Reported for Procedures Using Fluoroscopy
- #146: Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening
- #147: Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy
- #183: Hepatitis C: Hepatitis A Vaccination in Patients with HCV
- #184: Hepatitis C: Hepatitis B Vaccination in Patients with HCV
- #185: Endoscopy & Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps- Avoidance of Inappropriate Use

Consideration of Additional Measures Groups

The AMA requests that the Dementia measures that were submitted for the 2012 Call for Measures be considered for a measures group. The Dementia measures submitted include:

1. Dementia: Staging of Dementia
2. Dementia: Cognitive Assessment
3. Dementia: Functional Status Assessment

4. Dementia: Neuropsychiatric Symptom Assessment
5. Dementia: Management of Neuropsychiatric Symptoms
6. Dementia: Screening for Depressive Symptoms
7. Dementia: Counseling Regarding Safety Concerns
8. Dementia: Counseling Regarding Risks of Driving
9. Dementia: Palliative Care Counseling and Advance Care Planning (**Note**: this title has been slightly modified from what was submitted for consideration based on the review of the PCPI public comment period suggestions and further discussion with the measure development workgroup. The former title was Dementia: Comprehensive End of Life Counseling and Advance Care Planning.)
10. Dementia: Caregiver Education and Support

Retirement of Quality Measures
The AMA urges that the decision of whether to retire a measure or not be left to the measure developers. The AMA-PCPI has a thorough process for reviewing measures for retirement, including reviewing any relevant testing data, gaps in care and guideline support for the measure(s) in question.

Transitioning to ICD-10-CM
The AMA-PCPI is prepared to incorporate ICD-10-CM codes into all AMA-PCPI measures in the PQRS for the 2013 program year. We have begun to incorporate ICD-10-CM codes into our measure specifications, and expect to complete this transition by June 30, 2012.

Physician Quality Reporting Criteria -- Measures Groups
Claims-Based Reporting
The AMA urges CMS to continue all of the PQRS reporting options for submitting quality measures under the PQRS, including claims-based reporting. While we support the transition to increase the number of quality measures reportable via EHRs, the AMA supports maintaining claims-based reporting, as many providers have not yet implemented an EHR into their practice. Although claims-based reporting may be imperfect and prone to errors, it is imperative to maintain this reporting option until all other options and CMS operating systems reach "the 21st century" level and are fully operative and effective. Retaining the claims-based reporting option will continue to allow broader participation of physicians, and minimize the barriers to participate in the program.

Registry-Based Reporting
For the 2011 PQRS, CMS has posted on its web site a list of qualified registries, including the registry name, contact information, and the 2011 measure(s) and/or measures group(s) and e-prescribing reporting (if qualified) for which the registry is qualified and intends to report. The AMA and other stakeholders have urged CMS to post additional registry information, including cost to participate; number of past or current participants; frequency of registry feedback reports; and success rate of participants. CMS has not yet posted this information. **The AMA urges CMS to include these additional topics of information to better assist physicians in selecting a registry most appropriate for their practice. In**

addition, the AMA recommends that PQRS participants have an opportunity to file complaints directly with CMS regarding particular registries.

Physician Quality Reporting: Electronic Prescribing

Electronic Prescribing

While the AMA supports CMS' decision to only require that a physician report the eprescribing G code, G8553, ten times for applicable Medicare office visits and services on Medicare Part B claims, we do not support CMS' decision to back date the reporting period to 2011 in order to impose 2012 and 2013 penalties against physicians for failure to eprescribe. CMS' last minute decision to back date the e-prescribing penalty program has left very little time for CMS, the AMA, and other stakeholders to educate physicians about the penalty program, and to enable physicians to prepare to e-prescribe within the first few months of 2011 to avoid penalties. **Financial penalties should only be levied in 2012 and 2013 against Medicare eligible physicians who fail to qualify for an exemption and fail to e-prescribe ten permissible prescriptions by the end of 2012 or by the end of 2013.**

On January 18, President Obama issued an Executive Order calling on all government agencies to better balance projected benefits and costs and reduce the administrative burdens imposed by federal regulations. In compliance with this Executive Order, the AMA urges CMS to issue immediately a technical correction that would in effect base the 2012 penalties for the e-prescribing program on 2012 data.

The AMA is also disappointed that CMS decided to only allow claims-based reporting to avoid penalties and did not come up with any options for physicians to use a qualified registry or EHR to report e-prescribing activity. This means that physicians who use a qualified registry or EHR will also have to submit claims with the G code - duplicative work- in order to avoid a penalty.

The AMA also recommends that CMS add additional exemption categories to minimize the number of physicians who would face penalties. Anticipating that issues may come up that would warrant exemptions from the e-prescribing penalty, Congress rightfully authorized the Secretary of HHS to develop categories for exempting eligible physicians and other health care professionals from penalties. In the proposed physician fee schedule rule for 2011, CMS encouraged commenters to come up with recommendations for exception categories. CMS' decision to only accept its own proposed exception categories and dismiss all of the exception categories recommended by commenters is unacceptable. **CMS has an opportunity to minimize the financial and administrative hardships created by the various, overlapping Medicare incentive and penalty programs by establishing additional exemption categories from penalties.** For example, physicians who attest to meaningful use in 2011 or 2012 should be exempt from e-prescribing penalties. As discussed in more detail below, it is also critical that CMS work with the Office of the National Coordinator for Health Information Technology (ONCHIT) to

harmonize e-prescribing reporting criteria so that it is the same for the CMS e-prescribing and EHR incentive programs.

The AMA supports reviewing Part D data to determine e-prescribing activity and looks forward to receiving more details from CMS regarding this possibility.

Alignment of Various CMS Initiatives

We urge CMS to synchronize the various, overlapping Medicare incentive programs so that, for example, eligible physicians who receive Medicare EHR incentives will be exempt from the Medicare e-prescribing penalties. In February 2011, the GAO released a report recommending that CMS expedite efforts to remove the overlap in reporting requirements for physicians who may be eligible for incentive payments or subject to penalties under both the e-prescribing and EHR programs. The GAO further recommended aligning the reporting requirements so that successfully qualifying for incentive payments or for avoiding penalties under the EHR program would likewise result in meeting the requirements for the e-prescribing program. The GAO concluded that inconsistencies in these programs may limit the programs' effectiveness in encouraging the use of health information technologies. **Efforts must be made now, not later, to align these programs in order to alleviate confusion and the imposition of unreasonable financial and administrative burdens on physician practices. The AMA is concerned that if such efforts are not made immediately, it will seriously hamper the widespread adoption of health information technology.**

Further, it is critical that CMS acknowledge the lack of alignment in reporting methods between the PQRS and the EHR Incentive Program (meaningful use, or MU). For example, the MU program requires a quality measure to be calculated within the certified EHR Technology, whereas for PQRS EHR reporting, the EHR vendor must be a "designated PQRS EHR Vendor," and raw data is sent to a data warehouse with the measure being calculated outside the physician's EHR system. We emphasize that in order for quality measures to truly enable quality improvement, the data must be available to physicians at the point of care, and we encourage the model to calculate the measure be within the EHR system. This will be an important factor as CMS considers a plan for alignment of the two programs on or before January 1, 2012, as required.

The AMA remains committed to collaborations with CMS to maintain PCPI measures in CMS programs. The AMA appreciates the model used for PQRS involving measure developers, including the PCPI, and we recommend that a similar model be used for the CMS EHR Incentive Program.

<u>Maintenance of Certification Program Incentive</u>

CMS has requested comments on whether the agency should consider patient experience survey results in the future for purposes of qualifying for an additional incentive payment under the maintenance of certification (MOC) reporting option. Under the Patient Protection and Affordable Care Act (ACA), physicians would provide information on the survey of patient experience only "if requested by the Secretary." The AMA urges CMS not to require patient experience information at this time. Currently, collection methods

and data accuracy associated with patient experience lack uniformity and validity. Further, since the MOC reporting option is in its infancy (this option is available only as of 2011), CMS should use this time to focus on and evaluate problems, concerns, and barriers to successful participation under this option, especially before considering the addition of new requirements, such as patient experience information.

We recognize that the ability of physician offices to capture actionable patient experience data can support quality improvement efforts. It is from this perspective that the AMA has developed a patient satisfaction survey tool to help physician offices collect patient experience survey information via email. Data collected through this tool is not publicly reported, but used by the physician practice to identify opportunities to improve patient experience. The AMA will continue to promote and evaluate use of this patient experience tool.

The AMA also urges CMS to clarify certain questions regarding the MOC reporting option. Specifically, how would the MOC reporting option apply to eligible professionals (EPs) in the GPRO I and GPRO II options, especially regarding a multi-specialty group practice, where EPs would participate in different Board MOC processes? Would the GPRO receive the full 0.5 percent additional MOC incentive based on all EPs in the GPRO, even if not all EPs participated in the additional MOC option, especially in the event that an EP cannot participate because their specialty Board did not self-nominate?

Timely Feedback

Section 3002(e) of the ACA requires the Secretary to provide timely feedback to physicians on their performance with respect to satisfactorily submitting data on quality measures. CMS has not taken any steps to implement this timely feedback requirement, and the AMA is disappointed that CMS' feedback program for 2011 is merely consistent with current practices, which are extremely problematic. We urge CMS to immediately implement this provision of the ACA. **Current practices are unacceptable and fall well short of the statutory requirement and intent; we urge CMS to revise it to ensure that the feedback process improves successful participation in the PQRI program, as is intended by section 3002(e).**

Issuing feedback reports long after the reporting period has ended is not timely. Physicians cannot improve their understanding of program criteria or participation in a timely manner when there is such significant lag time between participation and distribution of feedback reports. To be effective, reports must be distributed at a point during the reporting period so as to allow physicians to assess their reporting and performance status, and revise their reporting practices, if needed, to be a successful participant. These reports should be confidential and can be a first step toward promoting internal quality improvement within a practice and ensuring that physicians are reporting correctly early in the program. They are also needed to provide physicians with timely, actionable information on potential problems in their PQRS reporting. Without timely feedback, physicians are unable to improve care at the point of care, which is the ultimate goal behind quality measurement.

The AMA has long been working with CMS to improve the feedback report process. Yet, feedback reports have not been distributed in a timely way, and therefore Congress enacted section 3002(e) to ensure timely reports. If Congress had intended that CMS simply continue with its current feedback practices, it would not have enacted section 3002(e). Thus, it is clear that to meet the intent of this section, CMS must implement a feedback report process that improves current practices.

It would be helpful if CMS issued monthly aggregate feedback reports to help physicians identify common errors in reporting, *e.g.*, incorrect gender, diagnosis code, CPT code. These reports should be posted on the CMS PQRS Web site and distributed to medical specialty organizations in advance to ensure this information is available for educating specialties about measure reporting errors. The AMA would be happy to help CMS facilitate improved distribution of the aggregate feedback reports.

Further, year-end aggregate reports must contain critical, material information, such as the total number of PQRS participants, total number of successful participants, average incentives payments, and a break down of the foregoing information by reporting options, *i.e.*, claims-based, registry, EHR, MOC, and 6-month versus 12-month reporting periods. CMS provided this level of detailed program information for the 2008 program, but not for the 2009 program year. We strongly urge CMS to publish, as soon as possible, detailed 2009 program information.

Finally, individual physician reports should be presented in summary form as one comprehensive snapshot, with links to further expand upon specific details of the report. Currently, individual reports are too lengthy and diffuse and therefore difficult to review and quickly and easily use as an educational tool.

Physician Quality Report Period Beyond 2012

CMS has requested information concerning how PQRS performance information should be used on the Physician Compare Web Site. Currently, there are significant amounts of incorrect data concerning physicians on the Physician Compare Web Site, and this information must be corrected. **The AMA urges CMS first to focus substantial resources on ensuring that the Physician Compare Web Site contains correct information for physicians listed on the web site before considering adding any additional information.**

The AMA appreciates the opportunity to participate in the 2012 PQRS Town Hall Meeting and provide our views on the critical foregoing matters. We look forward to continuing our work with CMS to constructively resolve the issues raised above.