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August 27, 2014

Marilyn B. Tavenner
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS-1612-P, Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015; Proposed Rule (Vol. 79, No. 133), July 11, 2014.

Dear Ms. Tavenner:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) physician fee schedule (PFS) proposed rule for calendar year (CY) 2015.

Our detailed comments (attached) address CMS's proposals related to: clinical lab local coverage determination policies; proposed changes to the clinical lab fee schedule; and the electronic health record incentive program. However, several areas of comment deserve particular emphasis:

- The AHA supports CMS's proposal to add seven new codes to its list of approved Medicare telehealth services and encourages the agency to consider adding other services in future rulemaking.
- The AHA is pleased that CMS recognizes the need to pay for services related to chronic care management (CCM), but we suggest that CMS re-examine whether the rate of \$41.92 adequately reimburses providers for the full scope of services. We are concerned about CMS's proposal to expand the scope of services to include a new requirement that physicians billing CCM services must utilize electronic health record technology certified to the most recent version of certification criteria and ask for a delay in this requirement for the first three years that the CCM payment is in effect.



- The AHA understands CMS's interest in learning more about the relatively recent trend in hospital acquisition of physician practices, but we are concerned that the proposed methodology of creating a Healthcare Common Procedure Coding System (HCPCS) modifier to track services furnished in off-campus, provider-based hospital outpatient departments has not been considered thoroughly. We urge the agency to re-propose a data collection methodology that is less burdensome, test it among providers, make adjustments as needed and the provide ample time for hospitals to implement the change.
- The AHA agrees that monitoring and evaluation of innovative payment and service delivery models being tested by the Center for Medicare and Medicaid Innovation (CMMI) is necessary. However, the proposal to require CMMI participants to provide large amounts of individually identifiable health information raises significant privacy concerns and would impose a large administrative burden on hospitals participating in such models.

In addition, while the AHA shares CMS's goal of promoting physician quality improvement, we strongly urge it to adopt the following changes to its physician quality measurement proposals:

- CMS should not increase the maximum payment penalty of the Physician Value-Based Payment Modifier (VM) from 2.0 to 4.0 percent until it can adequately address the program's significant data reporting, risk adjustment and measure testing issues.
- Instead of requiring the VM apply to participants in the Medicare Shared Savings Program (MSSP) and CMMI initiatives, CMS should create a "VM Innovation Pathway" in which individual eligible professionals and groups participating in MSSP and CMMI initiatives are automatically given a zero percent adjustment in the VM. Such an approach could avoid potentially inappropriate comparisons of performance, strengthen the incentive for physicians to participate in innovative care delivery models and minimize the risk of sending "mixed signals" to physicians about their quality performance.
- CMS should not mandate the reporting of the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS) for the Physician Quality Reporting System (PQRS) until CY 2016 (affecting CY 2018 PFS payment) at the very earliest. While the AHA strongly agrees with the value of patient experience, physicians need more time to plan for the significant costs of implementing CG CAHPS.

Further, while the AHA is concerned about the proposed changes to the MSSP's measure set, we appreciate that the agency has proposed two changes that are responsive to the concerns raised by our members participating in the MSSP. Specifically, we applaud CMS for proposing to adopt predictable schedule for updating performance benchmarks, and to award bonus points to accountable care organizations demonstrating year-to-year performance improvement.

Finally, we are deeply concerned that physician payments will decline by an estimated 21 percent on April 1, 2015 due to the flawed sustainable growth rate formula. Cuts of this

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magnitude are unsustainable. We urge CMS to work with Congress to fix the flawed physician payment formula, and to do so in a manner that does not result in reduced payments to hospitals and other providers.

Once again, the AHA appreciates the opportunity to comment on the proposed rule and offer our comments and insights to improve the operation, fairness and accuracy of the Medicare program for its beneficiaries. Our detailed comments are attached. If you have any questions concerning our comments, please feel free to contact me or Melissa Jackson, AHA senior associate director for policy, at (202) 626-2356 or mjackson@aha.org.

Sincerely,

/s/

Linda E. Fishman

Senior Vice President

Public Policy Analysis & Development

**American Hospital Association (AHA)
Detailed Comments on the Physician Fee Schedule (PFS)
Proposed Rule for Calendar Year (CY) 2015**

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American Hospital Association (AHA) Detailed Comments on the Physician Fee Schedule (PFS) Proposed Rule for Calendar Year (CY) 2015

TRACKING SERVICES IN OFF-CAMPUS PROVIDER-BASED DEPARTMENTS

In the proposed rule, the Centers for Medicare & Medicaid Services (CMS) cites recent reports of hospitals acquiring physician practices at an increasing rate and integrating those practices as hospital outpatient departments. The agency also notes concerns expressed by the Medicare Payment Advisory Commission (MedPAC) about increased Medicare program payments and higher cost-sharing experienced by beneficiaries as a result of hospital acquisition of physician practices. However, there is one aspect in this development that is not often acknowledged: as the health system transforms the delivery of care to meet the goals of the Triple Aim – improving the patient experience of care, improving the health of the population and lowering per capita health costs – hospitals are responding by integrating with physicians to achieve better care coordination and patient outcomes.

To understand how this activity affects the Medicare program, CMS proposes to collect data beginning in calendar year (CY) 2015 to allow it to analyze the frequency, type and payments for services furnished in off-campus, provider-based hospital outpatient departments. Specifically, CMS proposes to create a Healthcare Common Procedure Coding System (HCPCS) modifier to be reported with every code for physician services and hospital outpatient services furnished in an off-campus, provider-based department of a hospital.

The AHA understands CMS's interest in learning more about the relatively recent trend in hospitals' acquisition of physician practices, but we are concerned that the proposed information collection methodology has not been fully and thoroughly considered. Implementation details are missing and the methodology is untested. Operational issues must be settled and adequately tested before full-scale implementation, and adequate time must be allotted for hospitals to adjust and operationalize their systems to accommodate this proposed change. We also believe that the data collection would be very costly, time-consuming and burdensome at a time when providers are drowning in data requests while implementing meaningful use and ICD-10, and answering to a plethora of program auditors. **We urge the agency to re-propose a data collection methodology with a full description of how providers would apply the proposed HCPCS modifier; test it among a set of providers; make adjustments and provide additional guidance as necessary and then provide ample time for implementation.**

Operational and logistical details are lacking in this proposal. For example, it is unclear whether the modifier would apply to the location where a service is ordered or to the location where it is furnished and to which services it would apply. A typical situation might be when a physician sees a Medicare beneficiary in an off-campus provider-based clinic; she draws a specimen for a clinical diagnostic laboratory test, which she then sends to the laboratory on the hospital's main campus, and she orders an X-ray, which the patient obtains on the main campus of the hospital. It is unclear whether only the evaluation and management service receives the off-campus provider-based modifier or whether all services, including the laboratory test and the X-ray

would receive the modifier. A further complication could occur when services are furnished in several different off-campus provider-based departments of the hospital. Again, it is unclear whether there would be some way to identify at which off-campus location each service was furnished.

Adequate time must be allotted for hospitals to operationalize such a complex and costly proposal. A single Medicare claim can include hundreds of lines of services spanning a period of up to 30 days and often including services furnished in different locations on and off a hospital's main campus. Hospital billing systems currently do not have a way to distinguish efficiently where a particular service is furnished when services are provided in multiple locations on the same claim. Hospitals would be required to make significant modifications to their billing systems and devote substantial resources to training staff on how to use the new systems. To implement CMS's proposal, our members tell us that they would have to create a separate chargemaster for their off-campus locations, containing all applicable procedure codes with the new proposed modifier "hard-coded" into the system. Finally, such a modifier would be burdensome and complicated because it would apply only to the Medicare program, requiring the maintenance of two separate coding structures, one for Medicare patients and another for all other insurers.

MEDICARE TELEHEALTH SERVICES

The AHA supports the CMS proposal to add seven new codes to its list of approved Medicare telehealth services. Specifically, CMS proposes to add the following services:

- Psychotherapy services: current procedural technology (CPT) codes 90845 (psychoanalysis); 90846 (family psychotherapy (without the patient present)) and 90847 (family psychotherapy (conjoint psychotherapy) (with patient present))
- Prolonged services in the office: CPT codes 99354 (prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (list separately in addition to code for office or other outpatient evaluation and management service)) and 99355 (prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (list separately in addition to code for prolonged service))
- Annual wellness visits: Healthcare Common Procedure Coding System (HCPCS) codes G0438 (annual wellness visit; includes a personalized prevention plan of service, initial visit) and G0439 (annual wellness visit, includes a personalized prevention plan of service, subsequent visit)

Covering these telehealth services will expand access to care for Medicare beneficiaries, particularly in rural areas. We are especially pleased that CMS has proposed to include certain behavioral health services on this list, given the important role of telehealth in providing access to these critical services. **We believe more services could be effectively and efficiently furnished using telehealth and we encourage the agency to consider adding other services on its own initiative in future rulemaking.**

CHRONIC CARE MANAGEMENT (CCM)

In the CY 2014 PFS final rule, CMS established a policy to pay physicians and qualified non-physician practitioners explicitly for care management services provided to patients with two or more chronic conditions, effective Jan. 1, 2015. Practitioners must provide at least 20 minutes of such services every 30 days in order to bill for CCM services, and can include non-face-to-face care management provided by clinical staff members. In this year's rule, CMS proposes a payment rate of \$41.92 for these services. **The AHA is pleased CMS recognizes the critical importance of managing care for Medicare beneficiaries with multiple chronic conditions and the need to pay for these critical services. However, we suggest that CMS re-examine whether its proposed rate adequately reimburses physicians and other practitioners for the full scope of CCM services.**

In the CY 2014 rule, CMS finalized the scope of CCM services to include the following:

- The provision of 24-hours-a-day, 7-days-a-week access to address a patient's acute chronic care needs;
- Continuity of care with a designated practitioner or member of the care team with whom the patient is able to get successive routine appointments;
- Care management for chronic conditions, including systematic assessment of a patient's medical, functional and psychosocial needs; systems-based approaches to ensure timely receipt of all recommended preventive care; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications;
- Creation of a comprehensive patient-centered plan of care based on a physical, mental cognitive, psychosocial, functional and environmental assessment and an inventory of resource and supports;
- Management of care transitions between and among health care providers and settings;
- Coordination with home and community-based clinical service providers; and
- Enhanced opportunities for a patient to communicate with the provider by telephone as well as the use of secure messaging, Internet or other asynchronous non face-to-face consultation methods.

CMS also stated in the CY 2014 final rule that it intended to develop standards in future rulemaking to ensure that practitioners billing for CCM services have the capability to fully furnish them. However, in this year's proposed rule, CMS states that it will not propose such standards since many of the standards it was considering are incorporated into the scope of CCM services or overlap with other Medicare requirements. We are pleased that CMS does not intend to propose additional standards. As we have previously expressed to CMS, additional standards beyond those the agency has defined already may be prohibitively burdensome to providers seeking to furnish these services.

However, we are concerned that CMS proposes to expand the scope of services to include a new requirement that physicians billing CCM services must utilize electronic health record (EHR) technology certified to the most recent version of the EHR certification criteria

adopted by the Secretary of the Department of Health and Human Services. It is very likely that there are physician practices that effectively coordinate patient care but have not yet fully implemented a certified EHR; in particular, not all types of physicians have access to certified EHRs that are a good fit for their specialty practice. And as CMS well knows, many physicians are still struggling to meet meaningful use requirements. **The AHA suggests that CMS delay this requirement for the first three years that the CCM payment is in effect.** In the meantime, CMS could allow physicians to attest how they are otherwise providing real-time access to patient information to all members of the care team. This would allow physician practices more time to implement certified EHRs while also meeting CMS's goal of ensuring that the care team has immediate access to the most updated information regarding the care plan.

Finally, the AHA supports CMS's proposals to eliminate the direct employee and direct supervision requirements it adopted in the CY 2014 rule. Specifically, CMS proposes to remove the requirement that a clinical staff member must be a direct employee of the practitioner or the practitioner's practice in order to count that staff member's time providing CCM services toward the 20-minute threshold. Similarly, CMS proposes to remove the restriction that CCM services provided by clinical staff under general – rather than direct – supervision may be counted toward the 20-minute threshold only if they are provided outside the practice's normal business hours. Eliminating these restrictions would provide physicians and other practitioners who furnish CCM services with greater flexibility to structure their practices in order to best provide these services to Medicare beneficiaries.

ACCESS TO IDENTIFIABLE DATA FOR THE CENTER FOR MEDICARE AND MEDICAID INNOVATION (CMMI) MODELS

The AHA agrees that evaluation of CMMI models is a necessary and important component of the work CMMI is doing to test innovative payment and service delivery models. In particular, we are pleased that CMMI intends to conduct a rigorous evaluation process, to include use of control groups. However, the proposed data collection policy raises significant policy concerns, is overly broad and would impose an administrative burden on providers.

CMMI's reference to requiring reporting of a broad swath of individually identifiable patient-level data raises significant privacy concerns for providers who would be required to report such data. Moreover, the agency has provided insufficient information to assure providers that, in responding to these data requests, providers would be in compliance with Health Insurance Portability and Accountability Act (HIPAA) requirements for the use and disclosure of protected health information (PHI). The word of CMMI/CMS alone does not suffice since it is the HHS's Office for Civil Rights (OCR) – not CMMI/CMS – that ultimately determines whether a particular provider is properly compliant and not subject to penalties. HIPAA requires that providers limit the use and disclosure of PHI to the minimum necessary to accomplish the intended purpose of the disclosure. It is difficult to see from the preamble discussion how providers could feel confident that disclosing the protected health information requested is done in compliance with the provider's HIPAA obligations. CMMI should work with OCR to issue OCR guidance stating that providers reporting data as part of a CMMI evaluation are doing so

consistent with their HIPAA obligations. Further, as a general principle, whenever CMMI requires data collection and reporting from providers participating in a CMMI model, it should clearly articulate how each request for data is consistent with providers' obligation to use and disclose only the minimum necessary to accomplish the intended purpose of the disclosure.

We also have concerns regarding the broad authority the agency proposes for itself to require that entities participating in testing CMMI models report information, including protected health information, that the HHS Secretary determines “is necessary to monitor and evaluate such model(s).” Such broad authority would allow CMMI to cast a wide net to require providers even tangentially involved in a CMMI project to report any data the agency decides it needs, with no advance notice or warning. CMMI has access to comprehensive data. On the other hand, providers are drowning in data requests while implementing meaningful use and ICD-10 and answering to a plethora of program auditors. CMS already collects and has access to the key data needed to examine whether CMMI models are achieving their intended goals. When CMMI requires additional data, it should first look to other federal government sources – such as Internal Revenue Service or Bureau of the Census data – before imposing new data collection and reporting requirements on providers. When those government data are not sufficient to evaluate a model, CMMI should make clear up front what the exact data collection and reporting requirements associated with a project will be and include those requirements in the project contract. This would provide participants with appropriate notice of what data they would be required to collect and report and would help minimize the burden on providers.

NEW CLINICAL LAB LOCAL COVERAGE DETERMINATION (LCD) POLICY

The AHA generally supports CMS's intent in proposing a new policy for clinical lab LCDs. As required by the Protecting Access to Medicare Act (PAMA) of 2014, CMS proposes a new standardized process that Medicare Administrative Contractors (MACs) must follow when developing LCDs for clinical diagnostic laboratory tests. CMS believes that this proposed new LCD process would allow for public dialogue, notification of stakeholders and expedited beneficiary access to covered tests.

However, we recommend that CMS retain a notice period prior to the final LCD becoming effective, rather than eliminating the notice period, as has been proposed. Specifically, we suggest that CMS shorten the current 45-day notice period to 30 days. This would balance CMS's interest in expediting beneficiary access to covered tests with the need to allow hospitals and MACs adequate time to implement any systems changes and associated training necessary to implement the new LCD. Eliminating the notice period would mean that hospitals and their vendors would have no time to make changes to their medical necessity software or update their front-end registration processes for providing advanced beneficiary notice of non-coverage.

RESCINDING CY 2014 CLINICAL LAB FEE SCHEDULE (CLFS) CHANGES

The AHA requests that CMS clarify how it will determine which hospital and health system laboratories will be required to participate in the upcoming collection of data on private payer rate information and how the collection will be conducted. Section 216 of the PAMA rescinds CMS's authority to make adjustments based on technological changes for tests furnished on or after April 1, 2014 and now requires CMS to implement a new Medicare payment system for clinical diagnostic laboratory tests based on private-payer rates, beginning Jan. 1, 2017. In the proposed PFS rule, CMS states it will use future rulemaking to establish the parameters for the collection of private payer rate information from laboratories and other requirements to implement the PAMA provision. The AHA offers its comments and recommendations concerning the implementation of Section 216.

The AHA urges CMS to explain clearly how it will determine which hospital and health system laboratories are required to report their laboratory cost data. The PAMA requires "applicable laboratories" to report the payment rate and volume of each Medicare-covered clinical diagnostic laboratory test paid by each private payer during the reporting period. These data will then be used to calculate the payment rates for Medicare laboratory tests starting in CY 2017. Given the wide variety of commercial insurer payment methodologies, we are concerned that implementing these reporting requirements will be difficult for both CMS and laboratories. Thus, we encourage CMS to work in an open and transparent manner with all stakeholders in order to ensure that it minimizes the reporting burden as much as possible within the scope of the law.

The law defines an "applicable laboratory" as a laboratory that derives a majority of its Medicare revenue from the CLFS or the PFS. However, Medicare payment for most hospital laboratory testing is incorporated into broader payment "bundles," i.e., bundled into the diagnosis-related groups under the inpatient prospective payment system (PPS) or conditionally packaged into the ambulatory payment classifications (APCs) under the outpatient PPS. The only laboratory tests that remain separately payable via the CLFS and the PFS are certain tests furnished in the hospital outpatient setting. These include molecular pathology tests, tests conducted using referred (non-patient) specimens, tests that are clinically unrelated to other services furnished to a hospital outpatient on the same day, and tests that are the only service furnished to a hospital outpatient on a given date of service.

Given these payment policies, it seems unlikely that there would be many hospital laboratories for which revenue for clinical diagnostic laboratory tests paid under the CLFS or the PFS would constitute the majority of their Medicare laboratory revenue, i.e., that would be considered to be "applicable laboratories" required to report under the PAMA. Moreover, only CMS can perform this complex calculation. Hospitals would not be able to verify the agency's determination independently since they have no way of knowing what portion of their overall Medicare inpatient and outpatient PPS revenues represents payments for laboratory tests, because, as mentioned earlier, payments for most laboratory tests are packaged. Further, health systems have multiple hospitals, which complicates the calculation even further.

Also, some commercial insurer agreements require hospitals to keep their negotiated payment rates confidential. **The AHA is concerned that requiring hospitals to report their laboratory payment rates for these insurers may cause them to violate these contracts. CMS must account for this circumstance in its policies.**

We also urge CMS to specify in rulemaking how hospitals should allocate a larger payment among each of the individual tests performed for the patient during an encounter. Hospitals do not always receive insurer explanations of payments that itemize reimbursement on a test-by-test/code-by-code basis, particularly in instances where a large number of individual tests was provided.

PHYSICIAN VALUE-BASED PAYMENT MODIFIER (VM)

The ACA requires CMS to implement a VM that would apply to Medicare fee-for-service payments for certain physicians on Jan. 1, 2015, and to all physicians and physician groups by Jan. 1, 2017. The modifier would result in differential physician payments based on the quality and cost of care. The law did not specify the amount of the VM, only that the VM program must be budget neutral. To determine physician performance on the VM, CMS uses the Quality Tiering Model (QTM). The QTM calculates two composite scores – one based on quality measures reported in the physician quality reporting system (PQRS), and another based on cost measures calculated by CMS. The QTM combines the quality of care composite score with the cost composite score, classifying each score into high, average and low performance categories.

Proposed Payment Adjustment. CMS proposes to increase the maximum downward payment adjustment under the VM program from 2.0 percent in CY 2016 to 4.0 percent in CY 2017. Additionally, for the first time, CMS proposes to apply the VM to physician groups of all sizes and to individual eligible professionals (EPs). The maximum penalty of 4.0 percent would apply to groups of 10 or more EPs that score poorly using the QTM, as well as to individual EPs and groups that do not successfully participate in the PQRS during the performance year. In contrast, CMS proposes that individual EPs and group practices of two to nine EPs that meet PQRS reporting requirements would be “held harmless” in CY 2017; that is, they would receive only upward or neutral payment adjustments under the VM. In the proposed rule, CMS indicates that increasing the maximum VM payment penalty, as well as expanding the VM to all physicians, would accelerate physician quality improvement activities.

While the AHA enthusiastically agrees with CMS’s goal of promoting physician quality improvement activities, we strongly urge CMS not to increase the VM payment penalty beyond its current level of 2.0 percent until it can adequately address several issues.

Specifically, the AHA is very concerned that the data reporting infrastructure of the VM does not provide timely and adequate information to physicians to understand their VM performance. Moreover, measures are added to the VM without testing to ensure they are accurate and do not have unintended consequences of measurement. Additionally, the VM’s risk adjustment approach is inadequate, and groups caring for more complicated patients appear likely to score worse than others.

Additionally, the AHA notes that doubling the maximum payment penalty to 4.0 percent is “too much, too fast.” A far more gradual approach, such as the congressionally-mandated levels and timing of the hospital value-based purchasing program (VBP) would be appropriate. The VBP program began with a 1.0 percent withhold in FY 2013, with the withhold rising by 0.25 percentage point in each fiscal year (FY) until it reaches a maximum of 2.0 percent in FY 2017.

Insufficient Data Infrastructure. The AHA strongly urges CMS to improve the timeliness and usefulness of the VM’s performance preview reports, the Quality and Resource Utilization Reports (QRURs). As we understand it, the purpose of the QRURs is to provide data to physicians on their performance on individual quality measures, as well as their performance on the VM. We certainly agree that physicians and physician groups should have the opportunity to preview their individual measure and VM performance. To date, unfortunately, physicians have had very limited opportunity to understand their performance on the VM. The most recent QRURs were released in late 2013 and provide data on CY 2012 performance. However, the first year of the VM uses CY 2013 data for calculating performance. CMS indicates in the proposed rule that the QRURs based on CY 2013 data will not be available until late this summer. As of this writing in mid-August, physicians still cannot see their CY 2013 performance data, which will be used to calculate their CY 2015 VM.

Moreover, the CY 2012 QRURs were created only for groups of 25 or more EPs, and CMS was able to generate QRURs for only 58 percent of those groups.¹ The smaller physician groups that will be affected by the VM beginning in CYs 2016 and 2017 will not receive any QRUR performance data until CMS releases the CY 2013 QRURs, which will include performance data for individual EPs and group practices of all sizes. The release of the 2013 QRURs could occur after the close of the comment period on this proposed rule, depriving the majority of EPs and other providers of the opportunity to see and more fully analyze these data that are critical to understanding how CMS’s proposal would actually work. We believe this is inconsistent with the purpose of and requirements for notice and comment rule-making. Therefore, we urge CMS not to finalize this proposal, but rather to re-propose it in future rule-making after it has provided all affected practitioners with the information about their practices that they need to understand the implications of the proposal.

We acknowledge that generating future QRURs for potentially hundreds of thousands of individual EPs and physician groups is a complex undertaking, and appreciate that CMS is focused on improving the content of the reports. For example, we appreciate that CMS estimated VM performance in the 2012 QRURs, even though 2012 performance data will not be used in the VM. Nevertheless, we do not believe that the potential payment penalty should increase without giving all groups the benefit of reviewing and understanding performance data so they may implement the necessary changes to avoid a payment penalty.

Adding Measures to VM Using a Step-wise Process. The AHA is concerned that several measures used to determine VM performance have never been adequately tested for assessing physician performance, and lack endorsement by the National Quality Forum (NQF). We urge CMS to suspend these measures from the VM until they can be adequately tested and endorsed by the NQF. We further urge the agency to adhere to a gradual, step-wise process for adding measures to future VM program years.

CMS calculates VM performance using two sources – measure data submitted by physicians via PQRS, and other measures that CMS itself calculates using claims data. However, many of the claims-based measures have never been tested or NQF-endorsed for assessing physician performance. For instance, as part of a physician group’s quality score, CMS calculates three claims-based composite measures assessing acute condition rehospitalizations, chronic condition rehospitalizations, and all-cause, all-condition hospital readmissions. It is challenging to appropriately adjust risk for measures that clump together patients with disparate reasons for being admitted, disparate secondary diagnoses and other clinically relevant factors. Risk adjustment is even more challenging when working solely from claims data, which have much less information on the specific health issues of each patient than the actual medical record. When risk adjustment is inadequate, physician groups caring for the most acutely ill patients bear the brunt of the proposed penalties. As described in the next section of this letter, this is precisely what we predict will happen based on the limited available data.

Additionally, in the CY 2014 PFS final rule, CMS added to the QTM’s cost composite score a Medicare spending per beneficiary (MSPB) measure that was specifically tested and NQF-endorsed for use in measuring hospital-level performance. Without NQF endorsement for physician-level performance and without being able to examine testing data, stakeholders have little assurance that these measures obtain reliable, accurate results.

For these reasons, the AHA recommends that CMS suspend the three claims-based quality composite and the MSPB measures from the program until they are adequately tested and receive NQF endorsement for measuring physician performance. These recommendations are consistent with those of the Measure Applications Partnership (MAP), which urged CMS not to use the measures, as currently constructed, in the VM. The MAP is an Affordable Care Act-mandated, multi-stakeholder group that provides input on measures used in federal programs in advance of formal rulemaking.

We also are concerned that these measures were added to a pay-for-performance program before physicians gained any experience with reporting them. **The AHA strongly believes that measures should be added to all pay-for-performance programs in a gradual, predictable step-wise fashion. We urge CMS to adopt such an approach for the VM in future years.** The AHA has advocated for a gradual phase-in of measures into pay-for-performance programs for several years. The core principles of this approach, as applied to the VM, are summarized below:

1. Measures implemented in the VM should be reviewed and endorsed by the NQF prior to inclusion in the program to ensure that each measure is important, scientifically sound, useable and feasible to collect. **The measure should be specifically endorsed for use in assessing physician performance at the group or individual EP level.**
2. CMS should use only those measures that are supported by the MAP. The MAP’s review is informed by HHS’s own National Quality Strategy (NQS), thereby allowing an assessment of whether measures support improvement in the most important areas.

3. Before being used in the VM, each measure should be reported to physicians using the QRUR for at least one year.ⁱⁱ This step provides physicians with an opportunity to gain experience with a measure and understand their baseline performance before it is tied to payment. Moreover, the overall results can be monitored to be sure that there is variation in performance; the causes for variation can be identified; appropriate adjustments for patient characteristics (such as severity of illness) can be made; and potential unintended consequences of measurement can be identified and addressed.
4. Monitoring of a measure’s performance should continue throughout its use in the VM.
5. When there is evidence of consistent and sustained excellent performance, the measure should be retired to create room for identification of additional improvement opportunities and inclusion of new measures.

Risk-adjustment Concerns. The AHA urges CMS to reassess carefully its risk-adjustment approach before increasing the potential payment penalty of the VM. We are concerned that the current combination of measures and scoring methodology may be systematically biased against groups treating more complicated patients. The CMS-commissioned 2012 QRUR Experience Report simulates group practice QTM scores, and provides preliminary insight on how groups may fare on the VM.ⁱⁱⁱ The report includes data on the distribution of QTM cost and quality performance by hierarchical condition category (HCC) scores. HCC scores are a proxy for measuring the clinical risk factors of patients – the higher a group practice’s HCC score, the more complex its patients are.

Unfortunately, it appears that group practices caring for patients with more clinical risk factors are significantly more likely to score as low quality and high cost (Table 1). Indeed, 23 percent of groups with high HCC scores (i.e., in the top quartile of all physician groups) are classified as low quality, while only 7 percent of all groups are low quality. Similarly, 31 percent of groups with high HCC scores score as high cost, while only 8 percent of all groups score as high cost.

Table 1: Distribution of cost and quality scores for group practices in the 2012 QRUR Experience Report

	Quality Score			Cost Score		
	Low	Average	High	Low	Average	High
All group practices	7%	84%	6%	5%	83%	8%
Groups with HCC Scores in Top Quartile	23%	67%	5%	2%	62%	31%
Average HCC Score	1.59	1.07	0.96	0.88	1.06	1.74

Source: Mathematica Policy Research, Experience Report for the Performance Year 2012 Quality and Resource Utilization Reports, January 2014, p. 41.

We appreciate that CMS’s QTM methodology provides a mechanism to adjust favorably the scores of groups that care for significant numbers of high-risk patients. However, it is troubling that, despite this adjustment, groups caring for higher-risk patients appear to fare worse on the VM. In order to address this issue, CMS should carefully assess the measures used in calculating

the composite scores to ensure they have been adequately risk-adjusted. CMS also should consider further revisions to the QTM methodology to ensure that some groups are not penalized simply because they care for more challenging patients relative to other groups.

Application of VM to Individual EPs and Groups of Two to Nine EPs. **While the AHA appreciates the intent of “holding harmless” individual EPs and groups of two to nine EPs, we caution that this policy could target differentially all other physician groups with VM payment penalties.** Indeed, while individual EPs and small group practices would have only upside risk, all other groups would be subject to both incentives and penalties. These other groups would effectively fund rewards for providers that do not bear any downward risk for performance.

The long-term goal of the VM must be to provide all participants an equal opportunity to be rewarded for strong performance and to be held accountable for poor performance. Ideally, the level of incentives and penalties should not be based on the size of the group practice or the complexity of its patient population. Rather, the level should be based on real underlying differences in performance. The entire field has been challenged to understand whether national benchmarks for cost and quality are comparable for individuals, groups and across the various physician quality reporting mechanisms. However, as noted in our comments about risk adjustment, the limited available data suggest that there is significant room to improve the fairness of VM penalties. Thus, a policy decision that increases the maximum payment penalty borne by only some groups could further distort an already uneven playing field.

To be clear, we do not object to holding individual EPs and groups of two to nine EPs harmless for their first year in the VM. However, to improve the fairness of the proposal, CMS could make the potential incentive amount smaller for individual EPs and groups of two to nine EPs. This approach would recognize the fact that larger groups bear more risk in the VM.

Application of VM to Non-Physician Providers. CMS proposes to exercise its discretionary authority under the ACA to apply the VM to non-physician individual EPs and groups of EPs billing under the PFS beginning in CY 2017. Non-physician providers include physician assistants (PAs), nurse practitioners, clinical nurse specialists and clinical psychologists. While non-physician providers have counted toward determining a group practice’s total number of EPs, the VM payment adjustment currently applies only to physician providers in a given group practice.

The AHA supports the long-term goal of applying the VM to non-physician providers. However, we recommend that CMS allow non-physician providers to gain additional measure reporting experience before including them in the VM program. The earliest we believe CMS could expand the VM to non-physician providers is for the CY 2019 VM determination. Non-physician providers have become an integral part of team-based care, and we agree that, over time, including them in the VM could help foster greater alignment of quality improvement efforts. Nevertheless, only a small proportion of non-physician professionals has participated in PQRS. In 2012, 39 percent of eligible PAs and 37 percent of eligible nurses participated in PQRS; the rate of PQRS participation among other non-physician EPs was just

over 16 percent.^{iv} While we expect the rate of participation to grow in subsequent years, these groups have had limited experience with reporting data. Additionally, very few have received QRURs to understand their baseline performance.

We agree that all members of the care team share accountability for quality improvement. But we urge that all providers be given a fair opportunity to gain experience with the measure submission process and to understand their baseline performance. If CMS delays the application of the VM to non-physician providers until the CY 2019 payment determination, then providers could submit a full year of PQRS data in CY 2015, thereby receiving 2015 QRUR feedback reports during CY 2016. This would give them sufficient opportunity to learn the PQRS measure submission process, understand their baseline measure performance, and undertake performance improvement efforts during CY 2017, which is the performance period for the CY 2019 VM.

Readmissions Measure. In calculating the claims-based all-cause, all-condition readmissions measure constituting one part of the QTM quality score, CMS proposes to increase the minimum volume necessary to calculate the measure from 20 patients to 200 patients. CMS states that increasing the minimum number of cases will increase the reliability of measure data.

The AHA applauds CMS for recognizing the reliability issues with the readmissions measure. However, before finalizing this proposal, we recommend the agency undertake an analysis to ensure this change will not result in disproportionate penalties for certain groups. CMS should assess, for example, whether groups with large numbers of procedural-based specialists (e.g., surgeons) would fare worse than primary care physicians or dermatologists on the measure because they are more likely to have hospitalized patients.

Application of the VM to Hospital-based Physicians. **The AHA has long supported a VM participation option for hospital-based physicians where their performance is based on measure data from the hospital IQR and VBP programs. We applaud CMS for soliciting comment on how to develop such an option.** We comment below on several policy issues raised by CMS in the proposed rule.

Attribution of hospital-based physicians. **The AHA recommends that CMS allow physicians and groups to self-designate whether they qualify as hospital-based.** CMS could allow physicians to self-designate hospital-based status through a process that is similar to how physician group practices currently self-designate for the PQRS program. If needed, the agency could set parameters that ensure a strong relationship between a physician and hospital. For example, CMS could require active membership on the medical staff or an employment contract. The agency could potentially validate the relationship using claims data elements, such as inpatient and hospital outpatient department place of service codes.

Scoring approach. The hospital VBP program and physician VM use two different scoring methodologies. The hospital VBP program calculates a Total Performance Score (TPS) that is comprised of performance measures across several domains – clinical care (which includes process and outcome measures), efficiency and cost reduction, safety and patient experience. By

contrast, the VM calculates two composite scores – cost and quality. CMS discusses several options for including VBP data in the VM score.

The AHA largely agrees with CMS’s preferred approach, which would ensure that hospitals and physicians are focused on the same measures, and promote alignment of improvement activities. The approach would include the VBP efficiency domain score in the VM cost composite, and include all or some subset of the VBP’s other measure domains in the quality composite. **However, we also recommend that CMS conduct further analysis to determine whether the same performance benchmarks for hospital-based physicians should be used compared to other physicians in the VM.** Comparing the performance of physicians using hospital measures to that of non-hospital-based physicians has the potential to introduce bias into the VM. It would be important to know whether these biases exist, and to incorporate appropriate scoring methodology adjustments to mitigate them.

Corrections Process. CMS proposes to establish, for the CY 2015 VM payment adjustment, an “informal inquiry process” that would allow individual EPs and groups to request limited corrections. CMS solicits comment on two different deadlines for the CY 2015 VM – Jan. 1, 2015 or “the end of February 2015.” CMS proposes that when it determines it has made a mistake in calculating a VM participant’s quality measures, it would classify the group as “average quality.” However, when CMS determines it has made an error in calculating a participant’s cost performance, it proposes to re-compute the cost measures. If a VM participant’s performance changes as a result of a review, then CMS proposes to change its tier on the QTM.

The AHA applauds CMS for establishing a corrections process for the VM, especially since such review processes already are in place for CMS’s other quality measurement programs. We generally support the agency’s proposals, but recommend a few modifications. Specifically, we recommend that CMS set a deadline of the end of February 2015 for the submission of correction requests. This would give physicians ample time to review their data. Additionally, we recommend that CMS explore whether it has the ability to recalculate a provider’s quality performance, rather than simply classify the provider as “average quality.” For example, providers may be able to submit a corrected measure calculation that CMS could use to calculate a correct score.

For CY 2016 VM payments (which use a performance period of CY 2014), CMS proposes to require VM participants to submit requests for corrections within 30 days of the release of QRURs. CMS suggests that the QRUR will contain sufficient data to allow VM participants to determine whether any errors have been made. If CMS determines it made an error in a quality composite score, the agency proposes to recalculate the quality composite, rather than classifying it as “average quality” as it would in CY 2015. **The AHA generally supports this proposal but recommends CMS pilot its 2014 QRURs with a small group of providers before the reports are released.** This would allow the agency to determine whether the reports are comprehensive enough to allow providers to validate their performance, and allow CMS to update them if needed.

APPLICATION OF PHYSICIAN VM TO PARTICIPANTS IN MEDICARE SHARED SAVINGS PROGRAM (MSSP) AND CMMI INITIATIVES

To date, CMS has not applied the VM to physicians participating in the Medicare Shared Savings Program (MSSP), the Pioneer Accountable Care Organization (ACO) model or other similar CMMI initiatives, such as the Comprehensive Primary Care (CPC) initiative. However, CMS states that the statutory requirement to apply the VM to all physicians and physician groups necessitates the application of the VM to individual EPs and group practices participating in MSSP and CMMI initiatives beginning in CY 2017. Given the key programmatic differences between the VM and the CMMI initiatives, CMS proposes a complex approach for determining MSSP and CMMI participants' cost and quality scores on the QTM. Depending upon its particular circumstances, a MSSP or CMMI provider could receive QTM cost and quality scores based on ACO data or on the standard QTM scoring approach. Participants also could receive automatically assigned scores of "average cost" or "average quality." Taken together, CMS suggests that this approach would facilitate a fair comparison of quality between MSSP and CMMI initiative participants and all others in the VM.

However, instead of requiring the VM to apply to participants in MSSP and CMMI initiatives, we strongly urge CMS to create a "VM Innovation Pathway" in which individual EPs and groups participating in MSSP and CMMI initiatives would be automatically given a zero percent adjustment in the VM. Those individual EPs and groups who still wish to participate in the VM should have the ability to "opt in," and could be scored using the approach CMS has proposed.

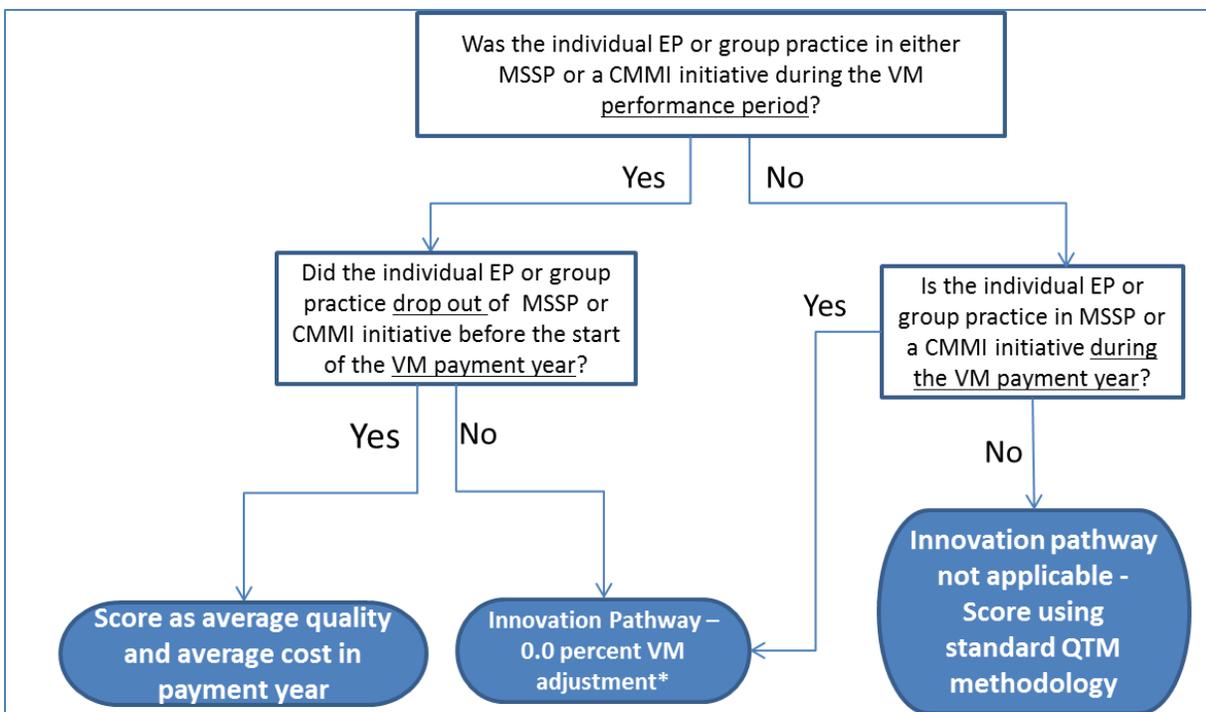
As discussed below in greater detail, the AHA believes the statutory language establishing the VM provides sufficient flexibility for CMS to implement an Innovation Pathway. Moreover, an Innovation Pathway for the VM could avoid potentially inappropriate comparisons of performance, strengthen the incentive for physicians to participate in innovative care delivery models and minimize the risk of sending "mixed signals" to physicians about their quality performance.

Statutory Flexibility. While we appreciate that CMS intends to meet a statutory obligation by applying the VM to MSSP and CMMI participants, we believe the statute provides sufficient flexibility for CMS to adopt an Innovation Pathway for the VM. CMS asserts that section 1848(p)(4)(iii)(II) of the Social Security Act requires it to apply the VM to all physicians and all groups by Jan. 1, 2017. However, section 1848(p)(5) of the Act also states that "the Secretary [of Health and Human Services] shall, as appropriate, apply the payment modifier... in a manner that promotes *systems-based care*.'" **We believe ACOs and CMMI initiatives encourage exactly the type of systems-based care contemplated in the statute, and that CMS would be permitted to modify the application of the VM to participants in those programs.** In ACO models, a variety of entities – physicians, hospitals, post-acute care providers – comes together to integrate and coordinate the care of patients across the care continuum to improve quality and efficiency. Similarly, the CPC initiative incentivizes primary care physicians for better coordinating the care of their patients.

Moreover, we note that the VM is a budget-neutral program in which all funds withheld from participating EPs and group practices must be redistributed to the program’s participants. Therefore, using an alternative approach to apply the VM for MSSP and CMMI participants would not impinge on any federally mandated level of incentive payment or savings. In fact, given that the MSSP and other CMMI programs are not budget neutral, implementing a zero percent adjustment would help ensure the integrity of the VM as well as other innovative non-budget neutral programs.

Implementation of a VM Innovation Pathway. The AHA’s recommended approach to implementing a VM Innovation Pathway for MSSP and CMMI initiative participants is outlined below in Figure 1. In general, any individual EP or group practice participating in a MSSP ACO or CMMI initiatives during both the VM performance period and payment year would use an “Innovation Pathway” in which they receive a zero percent adjustment in the VM. We also recommend that its data be excluded from the calculation of VM benchmarks. Individual EPs and groups that drop out of CMMI or MSSP before the VM payment year begins would be scored as average quality and cost, with one exception. That is, if the former CMMI participant joins MSSP, it would be eligible for the VM Innovation Pathway. Lastly, individual EPs or group practices that do not participate MSSP or CMMI initiatives during either the performance or VM payment year would be scored using the standard QTM. For example, participants in non-MSSP or CMMI ACOs would not be eligible to use the Innovation Pathway.

Figure 1: AHA-recommended VM Innovation Pathway for MSSP Participants



*If an individual EP or group practice drops out of a CMMI initiative but joins MSSP by the start of the payment year, then the EP or group would be eligible for the Innovation Pathway

Advantages of an Innovation Pathway. **A VM Innovation Pathway would minimize the risk of creating inappropriate comparisons of measure performance between ACOs and other VM participants.** In an attempt to reduce the likelihood of inappropriate comparisons, CMS proposes to calculate ACO VM quality performance using, in part, measures from the PQRS Group Practice Reporting Option (GPRO) web interface. The GPRO web interface measures also are used in the Pioneer ACO and MSSP ACO programs. However, CMS would not calculate all of the claims-based quality composite measures that apply to other VM participants. Instead, it would calculate only the hospital readmissions measure. Moreover, while it is true that ACOs use the GPRO web interface measures, there are important measurement differences between the programs. For instance, MSSP ACOs are accountable for performance on two claims-based measures – the Agency for Healthcare Research and Quality’s (AHRQ) Prevention Quality Indicators (PQIs) – that are not used in the VM. Moreover, ACOs have been benchmarked against other ACOs to date, and not against all other participants in the VM. The introduction of ACOs into the broader VM program could introduce potential bias – favorable or unfavorable to ACOs – into the broader program. Yet, CMS does not provide any data in the rule to identify whether the inclusion of MSSP and Pioneer ACOs in the program affects the VM’s benchmarks.

The differences between the VM and ACO programs underscore another important advantage of a potential VM Innovation Pathway – that is, it reduces the risk of physicians receiving mixed signals on their quality performance. While we appreciate that CMS has attempted to align VM and ACO measures, its proposal could still lead to ACOs scoring well in one program while performing poorly on the other. This is because the VM and ACO programs use different performance benchmarks and different approaches for determining good versus bad performance. For example, MSSP ACO quality performance is based on deciles of performance, and ACOs must surpass the 30th percentile of performance on measures to share in any savings. By contrast, the VM’s QTM categorizes physicians as having low, average or high cost and quality. VM performance is benchmarked against all physicians, while ACOs are benchmarked only against each other. While providers are committed to improving quality, resources for quality measurement and improvement are finite. Receiving mixed signals on quality performance makes it considerably more challenging to prioritize resources and execute improvements.

By contrast, a VM Innovation Pathway, with a zero percent adjustment, would allow individual EPs and group practices participating in MSSP and CMMI to be held accountable to a single, consistent pay-for-performance program. Physicians participating in ACOs could continue to focus on earning shared savings by achieving targets for quality and cost performance. Physicians would be able to dedicate more time to performance improvement, and less time on understanding why the performance results of the two programs may differ.

Moreover, the ability of physicians in ACOs to focus on a single pay-for-performance program is vitally important since physicians must make considerable investments to participate. When CMS implemented the MSSP, it estimated it would cost approximately \$1.8 million to form an ACO and operate in the first year. However, the AHA’s analysis, performed by McManis Consulting, estimated that these costs are much higher – \$11.6 million for a small ACO and \$26.1 million for a medium ACO. **A VM Innovation Pathway would free up**

resources that would otherwise be dedicated to improving VM performance, thereby strengthening the incentive for physicians to participate in innovative care delivery models.

PHYSICIAN QUALITY REPORTING SYSTEM (PQRS)

PQRS is a pay-for-reporting program that ties the successful reporting of quality measures to payment incentives through CY 2014 and payment penalties beginning in CY 2015. To earn an incentive or avoid a penalty, individual EPs and group practices are required to report data on quality measures for covered services provided to Medicare Part B recipients during an applicable data reporting period. As finalized in the CY 2013 PFS rule, a “group practice” is defined as having two or more EPs, as identified by their National Provider Numbers (NPIs), who have reassigned their Medicare billing rights to a single Taxpayer Identification Number. The AHA offers comments on several aspects of the PQRS’s GPRO below.

Mandatory GPRO Patient Experience Survey Reporting. In last year’s PFS rule, CMS finalized a *voluntary* option for group practices of 25 or more EPs to count the reporting of an expanded version of the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS) patient experience survey toward PQRS requirements. Groups may collect and report CG CAHPS data in CY 2014 to fulfill requirements for the CY 2016 PQRS program. However, in this year’s rule, CMS proposes to *require* all group practices of 100 or more EPs to collect and report patient experience data using the CG CAHPS survey. Data collection would begin in CY 2015 to meet the requirements for the CY 2017 PQRS payment determination. CMS would require group practices to use CMS-certified survey vendors to collect and report data, and to select one other GPRO reporting mechanism (e.g., web interface, qualified registry or EHR) to report other PQRS measures. CMS states that practices would be expected to bear the costs of CG CAHPS data collection and reporting. CMS further proposes to expand the requirement to report CG CAHPS by requiring group practices of 25 or more EPs to collect and report CG CAHPS during CY 2016 to meet the requirements of the CY 2018 PQRS program.

The AHA strongly agrees that patient experience surveys are valuable tools for improving care, and we continue to support the *voluntary* CG CAHPS reporting option for groups of 25 or more EPs. However, we urge CMS not to implement any *mandatory* reporting of CG CAHPS for groups of 100 or more EPs until CY 2016 (affecting CY 2018 PFS payment) at the very earliest. Providing sufficient time to comply with mandatory CG CAHPS reporting is critical given that providers are drowning in data requests to meet meaningful use, ICD-10 implementation and answering to a plethora of program auditors. We also are concerned about the substantial length of the version of CG CAHPS survey that would be used by CMS, and believe the agency should carefully assess whether all of the survey items are necessary before mandating it more broadly.

***Cost burden of CG CAHPS.* The AHA is disappointed that CMS chose not to estimate the cost burden of mandatory CG CAHPS reporting in the proposed rule and urges CMS to recognize the significant costs of collecting survey data.** While the CG CAHPS survey instrument is available free of charge, groups would be required to work with survey vendors to administer the surveys. In the proposed rule, CMS states it did not estimate the burden of CG

CAHPS reporting because "...[it] believe[s] that eligible professionals wishing to report CAHPS survey measures will do so for purposes other than the PQRS." Yet, CMS provides no data in the proposed rule to demonstrate that CG CAHPS is in widespread use for purposes other than meeting PQRS reporting requirements.

Moreover, group practices cannot simply take whatever CG CAHPS data they may already collect of their own volition and submit it to CMS. Rather, they must incur a separate expense to comply with CMS's mandated process for collecting and reporting CG CAHPS data for PQRS. CG CAHPS data for PQRS would be collected after the self-registration deadline for the GPRO. After the GPRO registration deadline, CMS attributes patients to a physician group based on whether that group provides the plurality of primary care services to the patient. CMS would then randomly select a sample of each practice's attributed patients to whom survey vendors would administer the survey.

Unfortunately, the data obtained using the CMS-mandated CG CAHPS data collection approach has limited usefulness for improvement purposes. Indeed, CMS's CG CAHPS approach attributes patients to practices at the end of each year, making it challenging for groups to track the experience of a stable patient population over time. The data are collected only once per year, covering a limited time period. The experience of our members in improving the patient experience suggests that routine data collection throughout the year is needed to prioritize and monitor the effectiveness of improvement efforts. Indeed, if CMS finalizes its proposal, it would be imperative for group practices to improve performance, as CG CAHPS data would be incorporated into the VM beginning in CY 2017.

To have the adequate and timely data needed to support improvement, group practices will supplement CMS-mandated data collection with their own data collection, thereby incurring additional expense. Our members currently using the CG CAHPS survey indicate they administer CG CAHPS throughout the year to ensure they have an adequate amount of current CG CAHPS performance data. Moreover, several of our members have found that collecting CG CAHPS data at the individual EP level has been critically important to improving performance. Individual EP-level CG CAHPS data help clinicians identify concrete areas where they can most improve. However, obtaining statistically reliable CG CAHPS data at the individual EP level entails significant data collection costs.

In the absence of a cost estimate in the proposed rule, the AHA undertook a preliminary analysis to determine how much it might cost for group practices of more than 100 EPs to implement mandatory CG CAHPS reporting. As detailed in the next paragraph, the estimate is based on available information on the costs of administering CG CAHPS and data on PQRS participation from CMS's 2012 PQRS Experience report. The findings of this analysis are summarized in Table 2. **We estimate that it may cost as much as \$30 million per year – or nearly \$517,000 per practice – for groups with more than 100 EPs to meet CMS reporting requirements and supplement CMS reporting with additional practice-specific data collection efforts.** Moreover, these estimates do not reflect any resources group practices might dedicate to analytic and improvement activities.

Table 2: Estimated PQRS CG CAHPS Data Collection and Submission Costs for groups of 100 or more EPs

	CMS-Mandated CG CAHPS Reporting			Supplemental CG CAHPS Data Collection			Total Impact		
	Cost per survey ^{vi}	Annual sample Size per practice ^{vii}	Number of group practices ^x	Subtotal	Annual sample size per EP ^{viii}	Number Of EPs ^x	Subtotal	Average cost per practice	Total cost of reporting
High cost	\$15.00	860	58	\$748,200	45	43,290	\$29,220,750	\$516,706	\$29,968,950
Mid cost	\$11.50	860	58	\$573,620	23	43,290	\$11,450,205	\$207,307	\$12,023,825
Low cost	\$8.00	860	58	\$399,040	10	43,290	\$3,463,200	\$66,590	\$3,862,240

Note: Sources are detailed in the endnotes on pages 32-33 of this document.

The AHA used the following approach and assumptions to create “high, mid and low” cost estimates:

- We assumed that group practices would incur costs for both the CMS-mandated CG-CAHPS survey, and for supplemental data collection for individual EPs throughout the year.
- We then estimated CG CAHPS per survey cost using two sources – a CG CAHPS survey implementation guide from AHRQ and a report from the Robert Wood Johnson Foundation. Taken together, these two sources suggest that administering the CG CAHPS via mail costs between \$8 and \$15 per completed survey.^{vi} We assumed \$15 per survey for the high-cost case, \$11.50 per survey for the mid-cost case and \$8 per survey for the low-cost case.

While not reflected in these estimates, it is important to note that some groups may use higher cost “mixed mode” survey administration in which mailed surveys are coupled with telephone-administered surveys. Mixed mode survey administration generally yields higher response rates, and CMS has used this approach with the CG CAHPS surveys it previously funded.

- For the CMS-mandated CG CAHPS data collection, we assumed that CMS would use a sample size of 860 patients per practice. This is consistent with the approach CMS has used for CG CAHPS survey administration for GPRO web interface practices.^{vii}
- For supplemental CG CAHPS data collected by practices on individual EPs, we assumed that practices would aim to collect 45 surveys per clinician per year. This is because AHRQ’s implementation guidance suggests that a minimum of 45 CG CAHPS surveys per clinician per year are needed for adequate reliability.^{viii} However, given the

substantial costs of implementing individual EP-level surveying, we assumed a sample size of 45 surveys per clinician per year for the high-cost case. We assumed that practices would collect half that amount – or 23 surveys per clinician per year – in the mid-cost case. For the low-cost case, we assumed that practices would collect only 10 surveys per clinician per year.

- To estimate the number of physician practices using the GPRO and the number of EPs within those practices, we used data from CMS's summary of PQRS participation in 2012.^{ix,x} We assumed that the same number of group practices and individual EPs would use the GPRO in 2015 as in 2012. However, using more recent data may show an increase in both the number of groups using the GPRO and, consequently, the number of EPs.

To be clear, the inclusion of these cost estimates is not meant to suggest that CG CAHPS data collection should never be required in future PQRS programs. However, physician groups need adequate time to budget for such substantial direct and indirect costs.

We also recommend that that CMS explore potential strategies for mitigating the cost of CG CAHPS administration. For example, CMS could consider allowing survey vendors to use less costly electronic survey administration modes, such as e-mailed, Web-based or smart phone-based surveys. The CG CAHPS survey administration protocol from AHRQ provides guidelines for administering surveys via e-mail, and CMS should allow practices to use them. Electronic survey distribution modes make survey data collection and aggregation less expensive, and may allow practices to increase sample size without greatly increasing costs. It also may allow for practices to integrate their CMS-mandated survey activities more tightly with supplemental survey activities.

***CG CAHPS tool concerns.* The AHA objects to the length of the mandatory CG CAHPS survey instrument, and urges CMS to consider ways of shortening it.** A survey of 81 questions is burdensome for patients and may yield low response rates. Low response rates from such a long survey would necessitate sampling a higher number of patients, which would increase survey administration costs. The version of CAHPS that CMS would implement is *almost 2.5 times longer* than the original NQF-endorsed CG CAHPS, which includes a total of 34 items. We appreciate that many of the additional questions are drawn from other surveys in the CAHPS family, such as the CAHPS Patient-Centered Medical Home Survey and the Core CAHPS Health Plan Survey Version 5.0. However, it does not appear that CMS has tested whether using this combination of survey questions provides meaningful data to providers.

As we understand it, the CG CAHPS tool, along with several other measures, will soon be reviewed by the NQF Patient and Family Centered Care Measures review committee. To the extent possible, we urge CMS to use this committee to review the version of the CG CAHPS survey it plans to use in PQRS. This review will ensure that the survey yields reliable data and that the questions, taken together, provide an accurate picture of performance with a minimum of burden on patients, physicians and other EPs.

GPRO Qualified Registry Reporting. As finalized in previous rulemaking, group practices of two or more EPs using either the qualified registry or EHR reporting options are required to report nine measures across at least three NQS domains. CMS proposes to modify these requirements by requiring that of the nine measures reported by groups, at least two measures must come from a new cross-cutting measure list that includes measures relevant to a variety of physician specialties. The measures assess issues such as tobacco use, vaccinations, patient falls and pain management. If a group practice does not have sufficient data to report nine measures covering at least three NQS domains, then CMS proposes that the practice would report up to eight measures covering one to three NQS domains for which there are sufficient Medicare patient data.

In general, the AHA supports this proposal. The AHA has long urged CMS to foster greater alignment of quality reporting efforts among physicians and between hospitals and physicians. In concept, asking physicians to report from a common list of measures may encourage alignment. However, we note that many of the measures on the list may not be relevant to hospital-based specialties, like radiology or pathology. Moreover, we ask the agency to clarify in the final rule whether group practices reporting less than nine measures must also report a measure from the PQRS cross-cutting measure list, as it is not explicit in the proposed rule.

MEDICARE SHARED SAVINGS PROGRAM (MSSP)

CMS proposes several changes to the MSSP's measure set, performance benchmarks and scoring methodology. The AHA is pleased that some of these proposed changes are responsive to the concerns raised by our members participating in the ACO program. Specifically, our members who participate in the MSSP are concerned that the quality measures used in the program are poorly aligned with both broader national quality improvement priorities, as well as with measures used in other CMS quality measurement programs. Moreover, our members have called for a more predictable, stable process for setting performance benchmarks, as well as stronger incentives for improved quality performance. **While we are concerned about the proposed changes to the program's measure set, the AHA applauds CMS for proposing a regular schedule for updating performance benchmark. We also commend CMS for its proposal to award bonus points to ACOs that demonstrate year-to-year performance improvement.**

ACO Quality Measures. CMS proposes several changes to the MSSP's quality measures that ACOs will collect in CY 2015 and report to CMS in early 2016. Specifically, CMS proposes to add 12 new measures, remove eight existing measures and update two existing measures.

Measure Additions. CMS proposes to add the following 12 measures to the MSSP measure set for CY 2015:

ACO-34: CAHPS Stewardship of Patient Resources. **The AHA does not oppose this measure, but has questions about its effectiveness in achieving better outcomes.** The measure asks patients whether the care team discussed prescription medicine costs with them. ACOs currently collect this measure as part of the CAHPS survey, but it is not used in determining ACO quality

performance. CMS proposes to include it as a scored measure in the MSSP and to phase it into pay-for-performance.

The AHA believes that discussions about prescription drug costs can be beneficial to patients and that it is important to identify when cost could pose a barrier to obtaining prescription drugs. However, simply discussing prescription costs, as the measure requires, does not ensure the creation of a modified plan that a patient with limited resources could follow more easily. CMS should explain more fully why it believes ACO-34 is important in measuring the beneficiary's experience with health care providers and what reasonable actions the agency believes the care team could be incentivized to take if a patient cannot afford his or her medications. We encourage CMS to share in the final rule its rationale about the potential for this measure to improve outcomes.

ACO-35: Skilled-Nursing Facility (SNF) 30-day all-cause readmission measure (SNFRM). This measure estimates the risk-adjusted rate of hospital readmissions for patients that have been admitted to a SNF within 30 days of discharge from an inpatient hospital, critical access hospital or psychiatric hospital. **We ask CMS not to include ACO-35 in the MSSP. While CMS believes this measure will incentivize providers to coordinate care among settings, we believe ACO-35 is the wrong measure to use to evaluate ACOs on care coordination.** This measure is intended primarily to serve as an indicator of the effectiveness of a SNF's operations. In the NQF documents providing background information for ACO-35, the developer explains that the rationale for the measure is to help consumers make better choices with regard to selection of a SNF. As we understand it, the measure was intended to promote accountability by SNFs for reducing readmissions, and it was envisioned that this measure would harmonize with readmissions measures designed to impact other providers, such as hospitals. Thus, each provider-type would have incentives, which would produce shared accountability for reducing readmissions.

Including ACO-35 in the MSSP might make more sense if all ACOs included both a hospital and a SNF. But that is not the reality. ACOs may not include a SNF at all and likely do not include all SNFs in the geographic area from which readmissions could originate. **We are concerned that ACO scores will be affected when beneficiaries return to an ACO-affiliated hospital after being discharged to a non-ACO affiliated SNF.** In such a case, CMS could be penalizing one or more stakeholders that this SNF readmission measure was not intended to evaluate.

While ACOs without a SNF might be incentivized to work with local post-acute providers due to the inclusion of this measure, they may be unable to achieve the same level of collaboration needed to affect change as compared to ACOs that include one or more SNFs. Thus, the inclusion of this measure will not provide an evaluation of similarly-situated ACOs for the purposes of determining performance.

Finally, we note that this measure is not NQF-endorsed, and **we urge CMS, at the very least, to postpone inclusion of this measure unless and until it receives such endorsement for its express use in the MSSP.**

ACO-36, ACO-37 and ACO-38: All-cause unplanned readmissions for patients with diabetes mellitus, heart failure and multiple chronic conditions. CMS indicates that these three measures are under development and would enhance the management of patients with complex chronic conditions. **We urge CMS to postpone inclusion of these measures in the MSSP unless and until they are NQF-endorsed. In addition, as with all readmission measures, we urge CMS to ensure they are adjusted for planned readmissions, unrelated readmissions and sociodemographic status.**

We believe that it is inappropriate for CMS to propose the inclusion of these measures before the development work has been completed. Interested stakeholders should be given an opportunity to review the details of a measure in order to evaluate its effectiveness. Proposing measures *before* they are fully developed deprives the public of the ability to comment effectively and deprives interested stakeholders of the opportunity to provide the kind of input envisioned for notice and comment rulemaking. Once the measures are fully developed, we would welcome the opportunity to review the specifications and provide appropriate comment.

ACO-39: Documentation of current medications in medical record. The proposed measure is endorsed by the NQF, and assesses whether medication reconciliation is performed at every ACO patient office visit. **The AHA supports the inclusion of this measure.**

ACO-40: Depression remission at 12 months. **The AHA supports this measure but has several concerns about how it will be incorporated into the MSSP.** This NQF-endorsed measure, which also is proposed for group practices, assesses the percentage of adult patients age 18 and older with major depression or dysthymia who demonstrate remission at 12 months. The measure includes those patients with a an initial patient health questionnaire (PHQ) score of greater than nine, and would use the results of a PHQ questionnaire administered 12 months later to determine whether there has been remission. Of paramount concern to the AHA is the lack of testing for this measure using the GPRO Web Interface. CMS notes that, “This measure is currently reportable in the PQRS program through the EHR reporting option only and has not been tested using claims level data or sampling methodology” (emphasis added). Ultimately, the AHA believes the measure addresses an important topic and has promise, but CMS needs to test the measure adequately before it becomes part of an ACO’s quality performance score. Testing would help evaluate how best to operationalize this measure, which is currently unclear. For example, while CMS indicates that collecting this measure may require “a look-back period and a look-forward period possibly spanning multiple calendar years,” the agency does not fully explain how providers will report information for patients who begin treatment in the middle of the year or who are not assigned to their ACO for the entire period in question.

ACO-41 and ACO-42: Diabetes measures for foot and eye exams. These two proposed NQF-endorsed measures assess the percentage of ACO patients with type 1 and 2 diabetes who receive foot exams and a retinal or dilated eye exam during the measurement year. **The AHA supports the inclusion of these measures. However, given that confusion exists about how to code the measure properly, we ask CMS to allow at least one year for ACOs to test and implement the measure at the practice sites before tying it to performance.**

Coronary Artery Disease (CAD) Measures. CMS proposes three new measures of care for CAD patients that would be incorporated into the MSSP's CAD composite measure. The NQF-endorsed ACO-43 (CAD antiplatelet therapy) assesses the percentage of CAD patients age 18 and older seen within a 12-month period that were prescribed aspirin or clopidogrel. ACO-44 assesses the percentage of adults with a diagnosis of CAD seen within a 12-month period that have had an evaluation for level of activity, and an assessment of whether angina symptoms are present or absent and whether angina symptoms are appropriately managed. The NQF-endorsed proposed measure ACO-45 reflects the proportion of patients with CAD who have prior myocardial infarction or left-ventricular systolic dysfunction that are prescribed beta-blocker therapy.

The AHA supports the inclusion of ACO-43 and ACO-45 as individual measures. However, we do not support the inclusion of ACO-44, as it is not NQF-endorsed. Moreover, we strongly urge CMS not to include any of its three proposed measures in the existing CAD composite. By including the three proposed CAD measures in the composite, CMS would be creating essentially a new composite that lacks NQF endorsement or even preliminary testing. When CMS significantly changes measures, including fundamentally altering composite measures, the agency should seek NQF endorsement before including the new composite in pay-for-performance programs.

Measure Removals. CMS proposes to remove the following measures from the program:

- ACO-12: Medication reconciliation after discharge from an inpatient facility
- ACO-22: Diabetes composite – Hemoglobin A1c control
- ACO-23: Diabetes composite – Low-density lipoprotein
- ACO-24: Diabetes composite – Blood pressure
- ACO-25: Diabetes composite – Tobacco non-use
- ACO-29: Ischemic vascular disease – Complete lipid profile
- ACO-30: Ischemic vascular disease – Use of aspirin or another antithrombotic
- ACO-32: CAD Composite – Drug therapy for lowering LDL cholesterol

The AHA supports CMS's proposal to remove these eight measures from the MSSP for CY 2015 reporting, as these measures are either redundant with other program measures or no longer reflect the most current clinical practice. However, when measure removal fundamentally changes a composite measure, CMS should seek review by NQF.

Measure Updates. CMS also proposes to update several of the MSSP's existing measures. CMS proposes to change both the CAD and Diabetes Mellitus composite measures for the MSSP. **As noted above, the AHA does not support the inclusion of a new CAD composite without NQF endorsement. We also urge the agency to seek NQF endorsement of its proposed changes to the diabetes composite measure before adding it to the MSSP.**

MSSP Performance Benchmarks and Scoring. CMS proposes several changes to its processes for establishing ACO program performance benchmarks.

Timing of Benchmark Updates. Several participants in the MSSP have urged CMS to implement a more predictable timeframe for establishing and updating numerical performance benchmarks. In response, CMS proposes to update performance benchmarks every two years. That is, benchmarks would apply for two performance years. However, the benchmarks used for that two-year period would be based on one year of data. For example, the benchmarks for the 2014 and 2015 performance years would be based on data from 2012, and the benchmarks for 2016 and 2017 would be based on 2014 data. **The AHA supports this proposal, and applauds CMS's efforts to implement a more predictable timeframe for establishing and updating numerical performance benchmarks.**

The agency also solicits comment on whether the benchmarks should be based on multiple years of data, rather than just one year (e.g., data from 2013 and 2014 would be used to set benchmarks for 2016 and 2017). **Given that the ACO measure performance period has a length of one year, the AHA does not believe it would be more beneficial for the benchmarks to be based on multiple years of data.**

Rewarding Quality Improvement. CMS proposes to revise its existing MSSP scoring methodology so that it explicitly rewards year-to-year improvement. Specifically, CMS would calculate ACO improvement points using an approach that includes: (1) assessing all measures that were scored in both the performance year and the year immediately preceding it for improvement (including any measures categorized as pay-for-reporting); (2) calculating year-to-year improvement and applying a t-test, (3) determining the measures for which the ACO achieved a statistically significant improvement and subtracting for measures for which performance declined; and (4) calculating up to two bonus points for each of the quality measure domains.

The AHA supports this proposal as a first step to reward quality improvement, and we encourage CMS to think even more strategically about how best to incentivize improvement that will achieve the greatest benefit for patients. For example, CMS might consider whether it makes sense to create an incentive program that allows an ACO to receive more points for improving outcomes that are the hardest to affect, for performing well on measures with higher reliability, and for adopting innovative solutions, such as creating new practices that can be shared with others.

Additionally, CMS could evaluate whether it would make sense to assign fewer points or less weight for measures that overlap, such as multiple readmission measures. We believe there are many things an ACO is already incentivized to do based upon the structure of the MSSP program, such as providing proper preventive care and early interventions, that will reduce the chance that a patient may require hospitalization. Therefore, as we consider the purpose of the quality measures in the MSSP program, CMS should evaluate whether the measures should strictly evaluate the things that an ACO already has encouragement to do, or whether measures could be selected and implemented in a way that promotes activity that has the greatest potential for positive impact on patients.

Benchmarks for ACO "Topped Out" Measures. CMS indicates that for some measures in the MSSP, the 80th or 90th percentile of performance approaches 100 percent. Thus, even though

performance is uniformly high, ACOs could receive different scores for very small – and clinically insignificant – differences in performance. Therefore, CMS proposes to assign flat percentages to measures where the 90th percentile of performance is greater than or equal to 95 percent. **The AHA supports this approach but believes there also is merit in CMS’s idea of removing topped out measures.** The AHA suggests that CMS develop criteria for when a measure should be removed similar to the criteria developed for the IQR program. In applying these criteria, however, we urge CMS to assess the broader context and uses of topped out measures carefully before removing them from programs. In limited cases, retaining measures that meet the quantitative criteria for being topped out may still provide value to patients and hospitals. Please see our comments on this subject in our June 26 comment letter related to CMS’s proposed inpatient PPS rule for 2015.

PHYSICIAN COMPARE

CY 2015 Reporting Proposals. For CY 2015, CMS proposes to expand *Physician Compare* reporting for group practices by publicly reporting all measures collected through all three of the PQRS GPRO reporting options – qualified registry, EHRs and web interface. Physician groups of all sizes participating in the GPRO web interface, as well as ACOs participating in the MSSP, would be included in the reporting. To publicly display performance on a measure, CMS requires a minimum volume of 20 patients. Group practices would have a 30-day period to preview their measure performance before data are posted to *Physician Compare*.

In general, the AHA supports transparency efforts, but urges CMS to assess carefully whether all of the measure data reported under the GPRO are sufficiently reliable and valid for public reporting before posting them. Transparency efforts are valuable to providers and patients only if the information provides an accurate picture of performance. If any of the measures is deemed unreliable or inaccurate, we urge CMS to remove it from *Physician Compare* and either improve the measure to an appropriate level of reliability or replace the measure with one that is more important and more reliable so that greater transparency is achieved within a shorter time.

CY 2016 Reporting Proposals. For CY 2016, CMS proposes to report CG CAHPS data publicly for all group practices that have met the minimum sample size requirements and collect the data using a certified CMS vendor. CMS would report 12 summary CG CAHPS scores, rather than reporting results on individual CG CAHPS questions. **The AHA supports this proposal.**

For CY 2016, CMS also proposes to report publicly composite scores that would be created by grouping together certain PQRS GPRO measures. CMS proposes to create composite scores for care coordination/patient safety, coronary artery disease, diabetes mellitus and preventive care. CMS indicates that it will undertake statistical analyses in 2015 to determine whether it is technically feasible to implement composite measures. CMS does not provide details in the rule about which GPRO measures would be part of each composite. **The AHA believes it is premature for CMS to propose these measures for public reporting without any evidence that they are reliable and accurate. Therefore, we recommend that the agency complete the development of the composites, get them NQF-endorsed and re-propose them in future**

rulemaking. While we certainly do not object to the notion of using composite measures, it is also difficult for us to judge whether these particular composites are suitable for public reporting when they appear to be in an early stage of development.

Lastly, CMS proposes to report group practice performance in a comparative manner by using a benchmarking approach that is similar to that of the MSSP. Specifically, CMS would establish benchmarks from the 30th to 90th percentiles of performance for GPRO measures, and award group practices points on each measure based on their percentile of performance. These points would be summed together and divided by the total number of available points to create an overall quality score for each group practice. CMS indicates that such a score would provide useful and accessible information to consumers.

The AHA supports the reporting of group practice measure performance in relation to national benchmarks. However, we do not support the calculation of an overall quality score. We do not believe the agency can create a single score that results in the fair comparison of all group practices. The GPRO reporting option includes three different measure submission modes – web interface, qualified registries and EHR reporting. Group practices using the web interface all report the same measures, but those measures are not always the same as those reported using registries and EHRs. It is unclear how CMS could calculate a total score that fairly compares all group practices' performance results when the measures used to determine quality are completely different. Even if CMS were to report a total score only for practices using the web interface, we would be concerned about the signal sent to the public by including a score only for those group practices and not others. For example, it would be inappropriate to conclude that some groups are not committed to quality because they do not have a total quality score.

Instead of calculating a total score, CMS should report the measures that each group has, and the national benchmark for those measures. CMS could then work with consumers and providers to iteratively refine the display of data on the website. We certainly share the agency's goal of making information on physician performance understandable and accessible to the public. However, we do not support approaches that could provide the public with a misleading picture of performance.

EHR INCENTIVE PROGRAM

Reporting Clinical Quality Measures (CQMs) with Current Electronic Specifications. In the final CY 2014 PFS rule, CMS adopted a requirement that EPs report the most recent version of the electronic specification for CQMs and have their EHR tested and certified to the most recent version of the electronic specification. In this year's rule, CMS acknowledges that it is burdensome to require EPs in the EHR Incentive Program to test and recertify their EHRs to the most recent version of the specifications for electronic clinical quality measures (eCQMs). Beginning in CY 2015, CMS proposes that EPs would not be required to meet the test and recertify requirement. However, the requirement to report eCQMs using the most recent version of the electronic specification would remain in effect. CMS also proposes, beginning in CY

2015, that if it discovers an error in the electronic specification, EPs would report the version of the electronic specification that was available immediately prior to the update.

The AHA supports the CMS proposal to not require EPs to test and recertify their EHR to the most recent version of specifications for eCQMs. It would be burdensome to require providers to test and recertify EHRs for conformance with annually updated specifications for eCQMs while EHR vendors also may submit the EHR to testing and recertification for other updates. Assurance of appropriate testing and certification of EHRs should remain the responsibility of the vendors of the products and in accordance with regulations governing the standards and certification of EHRs.

The AHA also supports the proposal to revert to the electronic specification that was available immediately prior to the update if an error is discovered in the most recent electronic specification. We request additional information on the notification process that will be used to inform EPs of specification errors sufficient to require the use of a prior specification. Additionally, we urge CMS to continue collaborating with measure stewards, measure developers, providers and EHR vendors to improve the development process and timeline for the release of accurate and reliable electronic specifications for clinical quality measures.

CQM Reporting Options. In the final CY 2014 PFS rule, CMS added a group reporting option for eCQM reporting for EPs who are part of a CPC initiative practice site that successfully reports at least nine electronically specified CQMs across three of the NQS domains for CQMs. In total, there are 64 CQMs across six NQS domains. For CY 2015, CMS proposes to retain the group reporting option for CPC practice sites but require the CPC practice site to report a minimum of nine CQMs from the CPC subset across at least two domains. The AHA supports the proposed flexibility for EPs in the CPC initiative practice site utilizing the group reporting option to report CQMs that are appropriate for the population of patients served.

ⁱ Mathematica Policy Research, *Experience Report for the Performance Year 2012 Quality and Resource Use Reports*, January 2014, p. 3.

ⁱⁱ In other contexts, we have argued that CMS should report measures publicly for at least one year before adding them to pay-for-performance programs. While we encourage CMS to consider this for some measures destined for the VM, we also recognize that technical challenges (e.g., adequate sample size) may make it undesirable to publicly report physician data.

ⁱⁱⁱ Mathematica Policy Research, *Experience Report for the Performance Year 2012 Quality and Resource Use Reports*, January 2014

^{iv} Centers for Medicare & Medicaid Services, *Appendix: 2012 Reporting Experience Including Trends (2007—2013): Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program*, March 14, 2014, page 30.

^v Emphasis added.

^{vi} The figure of \$8 per survey is based on two sources--implementation guidance from AHRQ, and a Robert Wood Johnson Foundation (RWJF) report. For group practices, the RWJF report estimates a cost of between \$8 and \$15 per completed survey. For individual clinicians, the AHRQ guidance estimates the cost to be \$360 per clinician to achieve a target of 45 complete surveys. Thus, the \$8 per survey figure is derived from $\$360 / 45 \text{ surveys} = \8 per survey . See Robert Wood Johnson Foundation, *Leverage Existing Efforts or Use a Centralized Approach: Two Strategies for Community-Wide Implementation of CAHPS Clinician and Group Survey*. Available at <https://cahps.ahrq.gov/surveys-guidance/cg/about/CGCAHPSUpdate.pdf>. CAHPS cost figures are on page 7. Also see AHRQ, *Fielding the CAHPS Clinician and Group Survey*, Sept. 2011, page 9.

^{vii} Based on CMS's 2013 approach to administering CAHPS surveys for PQRS GRPO practices over 100 EPs and ACOs. This approach is outlined in http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2013_PQRS_GPRO_ACO_CAHPS_Overview.pdf.

^{viii} Based on guidance for reliable clinician-level data provided by Agency for Health Care Research and Quality (AHRQ) in AHRQ, Fielding the CAHPS Clinician and Group Survey, Sep. 1, 2011, page 7. Available at https://cahps.ahrq.gov/surveys-guidance/survey4.0-docs/1033_CG_Fielding_the_Survey.pdf

^{ix} Based on number of groups that self-registered for the GPRO in 2012, and does not include MSSP ACOs or Pioneer ACOs. See Centers for Medicare and Medicaid Services, 2012 Reporting Experience Including Trends (2007—2013): Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program, March 14, 2014, page xv. Available at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2012-PQRS-and-eRx-Experience-Report.zip>

^x Based on number of clinicians in groups of over 100 EPs that self-registered for the GPRO in 2012. See CMS, 2012 Reporting Experience, page xv.