1730 M Street, NW, Suite 502
Washington, DC 20036

phone » (202) 659-9440
fax » (202) 659-9422
web » www.ahima.org

August 24, 2010

Dr. Donald Berwick
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1503-P
PO Box 8013
Baltimore, Maryland 21244-8013

Re: File Code CMS-1503-P

Medicare Program; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2011; Proposed Rule (75 *Federal Register 40040*)

Dear Dr. Berwick:

The American Health Information Management Association (AHIMA) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS') proposed changes to the Medicare Program; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2011 notice of proposed rulemaking (NPRM), as published in the July 13, 2010 *Federal Register*. Our comments focus on those areas of particular interest to our members.

AHIMA is a not-for-profit professional association representing more than 59,000 health information management (HIM) professionals who work throughout the healthcare industry. AHIMA's HIM professionals are educated, trained, and certified to serve the healthcare industry and the public by managing, analyzing, reporting, and utilizing data vital for patient care, while making it accessible to healthcare providers and appropriate researchers when it is needed most. AHIMA and its members also participate in a variety of projects with other industry groups and agencies of the Health and Human Services Department related to the use of secondary data for a variety of purposes including quality monitoring, reimbursement, public health, patient safety, biosurveillance, and research.

Our detailed comments and rationale on the NPRM for the Payment Policies under the Physician Fee Schedule are below.

§ 414.90 Physician quality reporting initiative (PQRI).

V. Provisions of the Patient Protection and Affordable Care Act of 2010

B. Section 3003: Improvements to the Physician Feedback Program and Section 3007: Value-based Payment Modifier Under The Physician Fee Schedule

3. Phase II Proposed Changes – We support CMS' intent to move away from proprietary episode grouping software, acknowledging the challenges and limitations it presented to the end users as well as CMS. Our members look forward to receiving details of the Medicare-specific episode grouper as soon as they are available on January 1, 2012.

We commend CMS for selecting an alternative set of information to collect as the ones highlighted in the proposed rule on page 40114. We are however, unsure as to why CMS has selected the chronic disease of prostate cancer in context of the other diseases identified. We believe this does not complement the others selected and suggest CMS use peripheral vascular disease instead which aligns more with those identified.

We commend CMS for acknowledging the challenges of conducting meaningful peer-to-peer comparisons for the purposes of the reports from the PQRI program where there is flexibility in which measures to report under this program. Selecting the core 12 measures that are consistently based upon claims provides the opportunity for baseline comparisons among physicians. We also support CMS' intent to link the PQRI program with the HITECH incentive program for meaningful use of electronic health records (EHRs). Aligning quality measurement programs is something AHIMA strongly supports as this reduces the burden and variability of reporting.

VI. Other Provisions of the Proposed Regulation

F. Issues Related to the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)

1. Section 131: Physician Payment, Efficiency, and Quality Improvements – Physician Quality Reporting Initiative (PQRI)
a. Program Background and Statutory Authority – Despite the fact that eligible providers are required, under the Patient Protection and Affordable Care Act of 2010, to participate in a Maintenance of Certification Program (MOCP) more frequently, we would like to share our endorsement of this effort. We believe this initiative will assist in improving the overall healthcare community and in particular the practice performance component of the program in the long term.

c. Proposed 2011 Reporting Periods for Individual EPs – AHIMA supports retaining the 2010 PQRI reporting periods as described in the proposed rule.

d. Proposed 2011 PQRI Reporting Mechanisms for Individual EPs – We support the number of options that CMS has presented as required for the quality measurement program. We are particularly pleased to see that EHR-based reporting capability is being enhanced and is aligning

with the meaningful use program reporting requirements. AHIMA supports the intent to lessen CMS' reliance on claims-based reporting for the very reasons outlined in the proposed rule – increased EHR adoption and abilities to report and positive registry experiences by both the EP and CMs. AHIMA strongly supports the consideration of modifying the current registry reporting methods to supply patient level data to CMS. Historically, and even in today's healthcare environment, we have encouraged uniformity and consistency in the use of data to reduce variability and improve comparability of data among EPs. We believe CMS could successfully implement this modification and leverage the processes and lessons learned from reporting in the RHQDAPU program for hospitals. We would, however, encourage CMS to implement consistent quality measurement reporting activities with those of the meaningful use program, particularly with those measures used for both programs.

We commend CMS for setting restrictions and criteria for registries in order to satisfy and become a qualified registry. By establishing boundaries and expectations it will ensure the level of quality and abilities of the registry to meet in order to support the reporting by EPs.

e. Proposed Criteria for Satisfactory Reporting of Individual Quality Measures for Individual EPs – We support CMS' intent to lower the reporting criteria from 80% down to 50%. We agree that this will encourage more participation in the program.

g. Proposed Reporting Option for Satisfactory Reporting on Quality Measures by Group Practices – AHIMA supports CMS' proposed definition of "group practice" as we believe this aligns with the current environment.

i. Proposed 2011 PQRI Quality Measures for Individual EPs – We support the considerations outlined on pages 40184-40185 regarding the selection of future measures for inclusion in the 2011 PQRI quality measure set. We suggest that further consideration be given, if not done so already, to those measures that will be retooled for future use in EHR reporting as well as those measures that must be retooled for the impending ICD-10-CM/PCS compliance date. We suggest that CMS further explore and discuss the phase-in dates in context with the ICD-10-CM/PCS transition date.

l. Other Relevant ACA Provisions
(2) Section 3002(c)—Maintenance of Certification Programs and Section 10327 Improvements to the Physician Quality Reporting System – As mentioned briefly regarding the MOCP, we strongly support the ***extra incentive of 0.5%*** for reporting through MOCP. The acceptance of quality measurement may be increased if outreach/education is provided by medical societies that require quality measurement data submission as a component of maintaining board certification through MOCPs. We suggest and support continued development of this component of the PQRI program as we believe this would influence the success of

participation by providers and attention to actionable measures leading to quality improvement because the information will be coming from a "trusted & credible" source of direct authority.

(3) Section 3002(d)—Integration of PQRI and EHR Reporting – We strongly support and look forward to the integration of PQRI quality measurement activities with those activities under the meaningful use incentive program and the continued momentum toward EHR reporting for PQRI. As previously noted in our letter, we have historically supported the movement toward uniformity and consistency in repurposing data and aligning programs where possible. There is much to be gained not only in improved comparability of data among peers, but also in reduced reporting burdens, increased standardization, and decreased costs associated with administrative requirements.

General Comments – The Patient Protection and Affordable Care Act of 2010 directs the CMS to create a national voluntary program for Accountable Care Organizations (ACOs) by January 2012. Provisions within this law call for the reporting of measures and possible alignment with the PQRI program. We are very interested in this pilot program and how it will complement or be integrated with the other quality measurement programs currently in place and we look forward to learning more about this program.

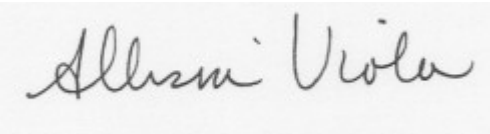
AHIMA suggests the addition of PQRI measures for 2011 be re-visited in context with the August 2010 publication of 69 NQF-endorsed® ambulatory performance measures that leverage clinically enriched administrative data.[1] The newly endorsed NQF measures are considered "an incremental step in the use of wider electronic platforms" and we believe this aligns with future efforts to integrate the PQRI and meaningful use program for EHR reporting efforts.

Finally, we believe it would be useful for participating EPs, as well as other stakeholders, if CMS developed a table that clearly summarizes the status of a measure's NQF endorsement, AQA endorsement, owner, and how the measure aligns with meaningful use clinical quality measure requirements. The information presented would enable the reader to quickly assess the information in a logical manner. We strongly encourage CMS to provide information, with respect to quality measures and their status, in this format in future proposed rules, final rules or any other publication where this information will be helpful particularly as CMS moves toward integration of the PQRI and meaningful use programs.

[1] "National Voluntary Consensus Standards for Ambulatory Care Using Clinically Enriched Administrative Data," National Quality Forum, accessed August 24, 2010, http://www.qualityforum.org/Publications/2010/08/National_Voluntary_Consensus_Standards_for_Ambulatory_Care_Using_Clinically_Enriched_Administrative_Data.aspx

If AHIMA can provide any further information or if there are any questions regarding this letter and its recommendations, please contact me at (202) 659-9440 or allison.viola@ahima.org, or AHIMA's vice president, policy and government relations, Dan Rode, at (202) 659-9440 or dan.rode@ahima.org. If we can be of further assistance to you in your efforts, we would welcome the opportunity to provide support.

Sincerely,



Allison Viola, MBA, RHIA
Director, Federal Relations

cc: Dan Rode, MBA, CHPS, FHFMA, Vice President, Policy and Government Relations