

February 25, 2011

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

RE: 2012 Physician Quality Reporting System Town Hall Meeting Comments

Dear Dr. Berwick,

The 28 undersigned organizations representing consumer, labor, and employer interests are submitting these comments regarding the 2012 Physician Quality Reporting System (PQRS).

Over the next year, CMS must make significant and rapid changes to PQRS to align the program with the vision for the health care delivery system that the health reform laws (e.g., the Affordable Care Act and American Reinvestment and Recovery Act) set forth: a patient-centered system of care that uses robust measures of performance to promote transparency and value-based payment of care.

PQRS has been in existence since 2007 and has been slow to demonstrate progress. As the program currently stands, an eligible professional can earn the bonus by simply reporting on three basic standards of care (e.g., screening asthma patients for tobacco use, providing tobacco cessation counseling for asthma patients who smoke, and one additional measure). The status quo is unacceptable.

CMS should alter the trajectory of the program to access its full potential to transform patient care. Specifically, the agency will need to:

- Focus on measures that assess meaningful levels of performance rather than adherence to minimum standards of competence;
- Focus on measures of outcomes, not just compliance with recommended processes of care;
- Facilitate comparability across relevant providers;
- Advance the availability and transparency of individual clinician performance; and
- Make PQRS data available for private sector innovation.

These changes are vital for PQRS to be used as a meaningful standalone program as well as useful to other federal and private sector initiatives. Those who receive and pay for care will be closely observing PQRS' progress and welcome the opportunity to provide further input into the process of strengthening the program.

INDIVIDUAL QUALITY MEASURES AND MEASURES GROUPS

The current suite of measures is not useful to consumers or purchasers

In its PowerPoint document, CMS outlines the potential of PQRS to impact: the Physician Compare website, the Value-based Payment Modifier, and the Physician Feedback Program. PQRS must therefore focus on robust measures that will effectively support consumer decision-making and payment that promotes high-quality, high-value care. The agency must place a much greater emphasis on measures that assess whether care truly made a difference for the patient, such as measures of outcomes (particularly for specialists), patient experience, health status, and care coordination and transitions. We also encourage the agency to focus on measures that address aspects of care where there is evidence of wide variation in performance across clinicians, high-cost and high-volume areas, and patients with multiple conditions. We recommend:

- Where such measures do not exist, the agency must commit to aggressively fund measure development in those areas, a strategy that the Office of the National Coordinator (ONC) has embarked upon.
- The removal of measures that do not substantively improve clinical performance or generate public utility. Specifically, we strongly recommend that the agency remove and avoid adding measures that:
 - **Assess basic competencies of care.** Allowing clinicians to be rewarded for what are basic standards of care will not drive significant improvements in patient care.
 - **Reflect processes that are not strongly linked to improved outcomes.**
 - **Document the presence of evaluation, assessment, and counseling.** Documentation measures do not assess the quality of the indicated service that was provided and often lack evidence linking them to any important outcomes. In fact, there is a poor relationship between such measures and patient outcomes.¹ For example, current measures of whether a clinician provided counseling on smoking cessation or healthy weight management – both of which are important elements – don't reveal how effective the counseling was. An alternative to using such measures would be to ask the patient to provide feedback on the quality of the interaction with the physician on particular issues (e.g., smoking cessation, healthy weight management, etc.), and in the longer term, to determine whether the patient's behavior actually changed in the appropriate direction. Additionally, it isn't enough to simply say that a clinician assessed or evaluated a person's condition (e.g., functional status, mental status, etc.). The results from the assessment/evaluation must be captured and reported to provide critical information to help clinicians and others to track which treatments are making a difference and which are not. Patients themselves are an excellent source of this type of information

There are a large number of measures within the PQRS 2011 list of measures that reflect these concerns, three of which are:

- Measure 148: Back Pain: Initial Visit
 - Measure 179: Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis
 - Measure 199: Heart Failure: Patient Education
- The addition of existing measures that resonate with consumer and purchasers. We are encouraged* by some of the potential measures for 2012 that have been put forth:

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

* Technical specifications on the measures were not provided so we were unable to do a complete assessment of all of the measures.

- M31 and M32 – Depression Remission at Six and Twelve Months
- M34 - Optimal Asthma Care
- M46 – In-Hospital Mortality Following Elective Non-ruptured Open AAA Repair
- M47 – In-Hospital Mortality Following Endovascular Abdominal Aortic Aneurysm Repair (EVAR)
- M49 – Postoperative Stroke or Death In Asymptomatic Patients Undergoing Carotid Artery Stenting (CAS)
- M50 – Postoperative Stroke or Death in Asymptomatic Patients undergoing Carotid Endarterectomy
- M51 – Rate of Carotid Artery Stenting for Asymptomatic Patients without Complications
- M54 – Rate of Open AAA Repair without Major Complications (discharged to home no later than post-operative day #7)
- M55 – Rate of EVAR without Major Complications (discharged to home no later than post-operative day #2)
- M56 – Rate of Carotid Endarterectomy for Asymptomatic Patients, without Major Complications (discharged to home no later than post-operative day #2)
- M77 - Cataracts: Improvement in Patient’s Visual Function within 90 Days Following Cataract Surgery
- M78 - Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery
- M79 - Functional Capacity in COPD Patients Before and After Pulmonary Rehabilitation
- M80 – Health-Related Quality of Life in COPD Patients Before and After Pulmonary Rehabilitation

CMS should also include other measures that are impactful to consumers and purchasers, such as:

- The Patient-Reported Outcomes Measurement Information System (PROMIS) item sets that allow for the measurement of improved patient-reported functional status across an array of conditions
- Optimal Diabetes Care measure by the Minnesota Community Measurement
- Patient experience surveys for providers who have an NQF endorsed CAHPS survey available – implementation in the real world has demonstrated that truly valid patient experience survey results are feasible and can be economically administered
- MRI lumbar spine for low back pain measure which was developed by CMS and endorsed by NQF

We are greatly concerned that a large number of the potential 2012 individual measures and measure groups, as well as many of the measures that have been a part of the program for a number of years, will not drive meaningful change or provide useful information for consumers and purchasers. We provide detailed comments on the proposed list of measures for 2012 in the **Appendix**, which we hope the agency will give careful consideration. For PQRS measures that have not been endorsed by the National Quality Forum (NQF), we encourage CMS to work with NQF to fast-track these measures through the endorsement process.

Adopt a core measure set to foster consistency and facilitate comparison across participants

We are encouraged to hear that the agency is considering using a core measure set. Consumers and purchasers have long advocated for this. We recommend that the core set of measures:

- Include measures of patient experience, outcomes (including patient-reported outcomes), and care coordination.
- Be comprehensive. The agency must steer away from its current requirement that individual clinicians report on only three measures, which does not supply a complete picture of the quality of care that a clinician provides. The increasing use of registries and EHRs by clinicians will reduce data collection burden on physicians and provide an opportunity for moving in this direction.

- Complement the *Meaningful Use* program to improve PQRS as well CMS' other programs.

Currently, the program allows individual physicians and small groups to self-select a few measures/measure groups to report on (e.g., individual physicians can choose as few as three measures). This strategy:

- Makes it difficult to compare the care provided across relevant professionals and allows professionals to select measures that they perform well on.
- Does not effectively support a consumer who is choosing a physician as the physician may not have chosen to report on areas of care that are relevant to the consumer.

The core measure set will be parsimonious to cover all eligible professionals. We therefore recommend that beyond the core measure set, specialists should report on additional measures that are specific to their patient population. For each common specialty or procedural service, specialists should report on a full dashboard of measures. Specialists could be required to report on a specific number of relevant measures in each of the following categories: clinical outcomes, health status, appropriateness of care, care coordination and transitions, patient experience and engagement, etc. For example, for colonoscopy there should be measures of volume, perforation and other complications, and admissions.

CMS should reach out to consumers and purchasers as it continues to refine what the core set entails, and consider how PQRS measures can help to advance the National Health Care Quality Strategy.

Set technical standards for measures that will result in higher quality data

We provide suggestions on technical criteria that measures should satisfy to result in better and more useful data. These include:

- ***Make exclusions evidence-based and explicitly defined.*** A number of PQRS measures have broad exclusions. Instead, denominator and numerator exclusions should be solely reflective of evidence-based clinical criteria and explicitly defined. For example, mammography screening would exclude women with bilateral mastectomy from the denominator. This recommendation is in line with NQF's Evaluation Criteria for scientific acceptability of measure properties. Explicitly defined exclusions will ensure that the removal of a patient from calculations of a provider's performance is justified – this will be a growing area of concern as PQRS data are used for value-based purchasing and consumer decision-making. Having more rigorous parameters around exclusions will also result in more informative data.
- ***Capture lab values on a continuous scale.*** Lab values, vital signs, and other results of care that can be captured on a continuous scale (e.g., LDL, HbA1c, blood pressure) should be captured on a continuous scale rather than in binary form (e.g., above or below a threshold value) that is tied to guidelines or opinions and subject to change. We encourage CMS to move in this direction as continuous data are key to understanding the actual impact of a treatment on a patient's health and tracking improvements in care. We therefore urge the agency to shift away from using CPT-II coding as it is unable to efficiently capture data on a continuous scale.
- ***Do not combine outcome and processes and report them as one measure.*** We want to ensure that the agency does not permit this activity, which masks outcomes. For example, consider temporary measure M13, "Coronary Artery Disease (CAD): Blood Pressure Control: Percentage of patients aged 18 years and older with a diagnosis of CAD with a blood pressure < 140/90 mmHg **OR** patients with a blood pressure ≥ 140/90 mmHg and prescribed 2 or more anti-hypertensive medications during the most recent visit during the measurement period. According to the measure

developer, the outcome should be reported separately from the process measure.² This recommendation also applies to measures 51 (COPD: Bronchodilator Therapy), M18 (Hypertension: Blood Pressure Control), M13 (CAD: Blood Pressure Control), and 53 (Asthma: Pharmacology Therapy).

Additionally, we are also concerned that measures like these may allow clinicians to obtain a “pass” for simply prescribing medications, when improving patient care often requires much more.

- **Standardization of assessment/evaluation tools.** There are a number of PQRS measures that simply require clinicians to “assess” or “evaluate” a patient’s health status. These measures fail to require that the actual results of these assessments be reported. Additionally, these measures often allow clinicians to select any relevant instrument to assess a patient’s health status. For example, M22 (Dementia: Cognitive Assessment) permits clinicians to use “One of a number of instruments, including several originally developed and validated for screening purposes. These may include, but are not limited to:
 - Blessed Orientation-Memory-Concentration Test (BOMC)
 - Mini-Cog
 - Montreal Cognitive Assessment (MoCA)
 - Cognitive Assessment Screening Instrument (CASI)
 - St. Louis University Mental Status Examination (SLUMS)
 - Minimum Data Set (MDS) Brief Interview of Mental Status (BIMS)”

Permitting uses of different instruments makes it difficult to compare performance results across clinicians. CMS must promote greater standardization in how health status information is collected and shared and we encourage the agency to work with consumers and purchasers on how to achieve this objective

ELECTRONIC PRESCRIBING INCENTIVE PROGRAM

Advancing e-prescribing is pivotal to improving patient safety. Unfortunately, the Electronic Prescribing Incentive Program sets the bar too low for determining “successful electronic prescribers,” a concern that we have voiced in previous years. We recommend that CMS should, at a minimum, require eligible professionals to electronically transmit at least 40% of appropriate prescriptions electronically, which is in line with the *Meaningful Use* incentive program.

REPORTING CRITERIA/OPTIONS FOR ELIGIBLE PROFESSIONALS AND GROUPS

Require individual eligible professionals, small groups, and large groups to report on enough patients to ensure sufficient reliability at the individual clinician level

Having reliable data at the individual clinician level is pivotal to facilitating consumer decision-making, promoting accountability, and accelerating quality improvement. By 2013, CMS should alter its approach to allow PQRS to achieve this objective. We provide this recommendation in light of some PQRS requirements that cause us concern in this area, namely:

- Setting a sample size of “at least 411” patients for larger groups (those with at least 200 eligible providers) will not foster reliable reporting on the individual clinicians within the group. Additionally, there is no reason that the measures specified for larger groups cannot be applied at the level of the individual clinician.

² The AMA-PCPI requires that the outcome be reported separately from the process by requiring the measure user to “report the number of patients for each numerator component separately AND a total.”

- In the past years, to increase provider participation, CMS has reduced the number of patients that individual eligible professionals must report on (e.g., for claims-based reporting, CMS reduced the percent from 80% to 50% of patients of their choosing seen during the reporting period). CMS should consider other activities to increase the participation of individual professionals. Lowering the number of patients that participating professionals must report on jeopardizes reliability and weakens the ability of the program to collect a comprehensive picture of how providers care for their patients.
- CMS currently offers eligible professionals two reporting periods, 12 months and 6 months. Reporting on a 6 month period may undermine reliability by reducing the denominator of applicable patients. The 6 month reporting period is also problematic if the purpose is to get reliable data to score performance at the physician level, which for some conditions could require a minimum of 2 years of data.

To produce reliable data, CMS could use a reliability threshold of 0.7 to be sure that the patient sample is large enough to yield consistent results, since the minimum sample size for reliable reporting varies considerably by measures and for individual physicians and practice groups. The agency should also consider the impact of allowing 6 month reporting periods on reliability.

We also encourage CMS to transition PQRS over time to requiring eligible professionals to report on all patients who qualify for the denominator, as this is critical to assuring validity. Currently, PQRS allows individual clinicians to self-select which patients they will report on.

Foster greater use of registries and EHRs while capitalizing on what claims data can offer in the interim

We support CMS' interest in advancing the use of registries and EHRs, which will become increasingly important sources of information, especially in light of the federal government's investment in *Meaningful Use*. However, the *Meaningful Use* program may not generate a critical mass of providers capable of reporting through EHRs until at least 2015. CMS should therefore promote greater EHR adoption by finding other avenues to make reporting PQRS data via EHRs and registries more attractive in the near term.

As PQRS transitions to a larger emphasis on EHRs and registries, CMS should consider how claims data can still be used to provide valuable information. Administrative claims data are the most readily available source of information at this time and despite their limitations, the data can still be effectively used to assess many aspects of performance, such as certain outcomes of care (e.g., mortality, complications, hospital readmission), process of care measures (e.g., immunizations, Pap smears, adherence to evidence-based guidelines on laboratory and medication orders), resource utilization, and cost-efficiency measures.³ Administrative data will also be improved in the coming years through the widespread adoption of a more sophisticated medical coding system (ICD-10).

THE MAINTENANCE OF CERTIFICATION PROGRAM INCENTIVE

CMS requests feedback on whether and how it should be collecting patient experience survey results from the Maintenance of Certification (MOC) program in which physicians participating in PQRS can receive an additional 0.5% bonus for meeting specific MOC requirements. CMS should collect patient experience data at the individual physician level. Besides resonating deeply with consumers, measures of patient experience assess whether patients are receiving the kind of care that will improve their outcomes and are good indicators of care quality for those with complex conditions. These measures are therefore important to assessing care for the large and growing number of Medicare patients with multiple

³ Consumer-Purchaser Disclosure Project, Using *Electronic Data for Performance Measurement*, October 2007
<<http://healthcareDisclosure.org/docs/files/UsingElectronicDataOct2007.pdf>>

chronic conditions who use the health system the most, generate the most cost and are vulnerable to poor quality, uncoordinated care. Evidence also shows that consumers care about how physicians are viewed by others like themselves and are seeking physician-specific information, not practice or group level.⁴

If CMS pursues public reporting of patient experience survey results, it should ensure that data are collected on clinicians in a standardized way that produces reliable results and comparability. The agency should also work with consumers and purchaser to make sure that the collected data is meaningful to patients.

PQRS SYSTEM BEYOND 2012

More commitment needs to be made to move PQRS forward

In its current state, PQRS will not be able to effectively support federal initiatives that are aimed at improving transparency, consumer decision-making, and payment decisions. Since its inception, consumers and purchasers have voiced concerns about the slow pace of PQRS' progress at the expense of public dollars. From the PQRS Town Hall meeting on February 9th, we see glimpses of a turning point for PQRS, with the agency introducing the possibility of a core measure set. However consumers and purchasers would like to see greater commitment from CMS to make PQRS more rigorous and responsive to their concerns.

PQRS performance data should be made publicly available

Beyond the topics that were covered in the Town Hall meeting, more discussion is needed on making PQRS data available at a granular level to the private sector, which has demonstrated innovation in putting performance information into the hands of consumers. This could be done in the form of an application-programming interface (API). HHS has already led the way in this area through its Community Health Data Initiative, which seeks to improve health by creating a growing "ecosystem" of community health data supply and use. HHS provided a major infusion of free, easily accessible community health data from the government, the private sector, and public crowd sourcing. It then encouraged innovators to build applications across an array of high potential uses of data (e.g., maps, dashboards, search engine tools, games). What came out of this effort was a wellspring of ideas and platforms that can reach a far greater breadth of consumers than HHS could achieve on its own.

The agency asks how PQRS performance information should be used on the Physician Compare website. We encourage the agency to review our letter to CMS on this subject, which is available at http://healthcaredisclosure.org/docs/files/DisclosurePhysicianCompareCommentLetter_11-30-10.pdf. In this letter, we advocated for Physician Compare to:

- Provide information that meets consumer needs, including performance measures that help consumers make decisions on doctor choice and treatment;
- Report information at the individual clinician level where variation in performance is most evident, and not just the practice group level, whenever feasible;
- Show differences in physician performance and ensure that variations across physicians are not unduly obscured;
- Balance the desire for methodological perfection with consumers' immediate need for information about how their physicians care for their patients; and
- Support the availability of comprehensive physician performance information for the website by fostering the growth of all-payer data.

⁴ Kaiser Family Foundation, AHRQ, Harvard School of Public Health, *National Survey on Consumers' Experiences With Patient Safety and Quality Information*, November 2004 <<http://www.kff.org/kaiserpolls/upload/National-Survey-on-Consumers-Experiences-With-Patient-Safety-and-Quality-Information-Survey-Summary-and-Chartpack.pdf>>. Conversation with Dr. Judith Hibbard on November 5, 2010.

Set criteria for PQRS in 2015 that serves the public interest

CMS requests input on the criteria it should use to determine its 2015 payment reduction, which will be applied to clinicians who do not submit required quality data. The agency must set a high bar. The criteria must address the key issues that we have outlined in this comment letter (e.g., require reporting on more and better measures, ensure reliable data, and promote comparability of performance across physicians).

In setting PQRS requirements for 2015, the agency should adopt a patient-centric approach for making beneficiary needs and interests primary.

CLOSING

On behalf of the millions of Americans represented by the undersigned organizations, we appreciate the opportunity to provide comments and hope that CMS begins to look through the lens of those who receive and pay for care in order to transform PQRS. If you have any questions, please contact either of the Disclosure Project's co-chairs, Debra Ness, President of the National Partnership for Women & Families, or Bill Kramer, Executive Director for National Health Policy of the Pacific Business Group on Health.

Sincerely,

AARP
AFL-CIO
American Benefits Council
American Hospice Foundation
The Buyers Health Care Action Group
Childbirth Connection
Consumers' CHECKBOOK
Consumers Union
Employers' Coalition on Health
Employers Health Coalition of Ohio, Inc.
Florida Health Care Coalition
Health Action Council Ohio
Health Care Incentives Improvement Institute
HealthCare 21 Business Coalition
Health Policy Corporation of Iowa
HEREIU Welfare Fund
HR Policy Association
Iowa Health Buyers Alliance
The Leapfrog Group
Mid-Atlantic Business Group on Health
National Business Coalition on Health
National Partnership for Women & Families
New Jersey Health Care Quality Institute
Northeast Business Group on Health
Pacific Business Group on Health
Puget Sound Health Alliance
South Carolina Business Coalition on Health
St. Louis Area Business Health Coalition

APPENDIX: 1

Below, we provide some thoughts on the potential list of new measure groups and individual measures for 2012. While there are a number of strong candidate measures, we are concerned that many of the measures put forth are not priority measures for consumers and purchasers and encourage CMS to prune back the list of measures. We also ask that CMS look closely at the potential measures with the criteria that we laid out in the "Individual Quality Measures and Measures Groups" section.

Measure groups

Cataracts (SMG01):

- We support the inclusion of the proposed cataracts temporary measure group. It critically assesses the patient's experience and the actual outcomes of care.

Pulmonary Rehabilitation: Option 1 (SMG02):

- CMS needs to articulate why PQRS needs different options for "Pulmonary Rehabilitation" and "Chronic Obstructive Pulmonary Disease."
- We support the inclusion of M79 (Functional Capacity in COPD Patients Before and After Pulmonary Rehabilitation) and M80 (Health-Related Quality of Life in COPD Patients Before and After Pulmonary Rehabilitation) as they capture the end result of care.
- We are concerned about the use of measure 52 (Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy) as it appears that this measure combines an outcome (i.e., whether the patient had a FEV₁/FVC less than 70%) and a process measure (whether the patient was prescribed an inhaled bronchodilator). If this measure is included, CMS should ensure that the outcome is reported separately to the agency (see the "Individual Quality Measures and Measure Groups" section for a further explanation of the need to avoid "combining" outcome and process measures), which is what the measure developer intended. We also are concerned that the measure provides clinicians with a "pass" for simply having prescribed an inhaled bronchodilator instead of the more intensive work that might be necessary to improve the outcome.
- We do not support adding measure 51 (Spirometry Evaluation) which only documents whether an evaluation occurred. It also appears to be redundant as measure 52 (Bronchodilator Therapy) already assesses FEV₁/FVC (the measurement of the amount and/or speed of air that can be inhaled and exhaled). If CMS wants to know if spirometry is specifically being used to assess FEV₁/FVC, measure 52 should be specified to require the use of spirometry in assessing FEV₁/FVC if it doesn't already do so.
- Measure 226 (Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention) does not assess the quality of the counseling. We suggest that an alternate and more optimal approach would be to ask the patient about whether they received counseling and whether it was effective.
- We encourage CMS to explore adding measures of hospital admissions and ER visits for COPD patients.

Pulmonary Rehabilitation: Option 2 (SMG03)

- We ask CMS to articulate why there is a need for an “Option 2” regarding pulmonary rehabilitation. Option 2 lacks measures that provide information on whether care made a difference for patients in their functional status and quality of life (i.e., M79 and M80).
- Please also see our comments in Option 1 regarding measures 51, 52, and 226.

Chronic Obstructive Pulmonary Disease: Option 1 (SMG04)

- It is not enough to measure lung functioning. CMS must include measures of functional status and quality of life. According to research “The traditional measure, spirometry, correlates poorly with important clinical features of the disease, such quality of life (QOL). Moreover, COPD has recently been recognized as a systemic disease, and its systemic manifestations, such as weight loss and muscle weakness, are only poorly related to lung function.”⁵ CMS can look into requiring clinicians to report results on a number of related tools (e.g., 6-minute Walk Test, the Saint George's Respiratory Questionnaire and the Chronic Respiratory Questionnaire).
- Please also see our comments on Pulmonary Rehabilitation, Options 1 and 2.

Chronic Obstructive Pulmonary Disease: Option 2 (SMG05)

- Please see our comments on COPD Option 1 and Pulmonary Rehabilitation Options 1 and 2.

Colon Cancer Screening (SMG07)

Many of the measures in this group simply capture whether the clinician documented the procedures performed and not the quality of those procedures. The measure group needs to assess volume, perforation, subsequent complications and admissions.

Dementia (SMG08)

These measures come at a time when there are very few measures in the U.S. to assess the care provided to patients with dementia and are therefore a positive step forward. However, we have a number of concerns about this set of measures which we expressed in detail in a letter to the measure developer, including the lack of measures of outcomes and care coordination. We would be happy to supply CMS with a copy of this letter.

⁵ <http://pats.atsjournals.org/cgi/content/full/2/4/267>

Individual measures

We are encouraged by the following potential measures:

- M31 and M32 – Depression Remission at Six and Twelve Months
- M34 - Optimal Asthma Care
- M46 – In-Hospital Mortality Following Elective Non-ruptured Open AAA Repair
- M47 – In-Hospital Mortality Following Endovascular Abdominal Aortic Aneurysm Repair (EVAR)
- M49 – Postoperative Stroke or Death In Asymptomatic Patients Undergoing Carotid Artery Stenting (CAS)
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- M78 - Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery
- M79 - Functional Capacity in COPD Patients Before and After Pulmonary Rehabilitation
- M80 – Health-Related Quality of Life in COPD Patients Before and After Pulmonary Rehabilitation

Technical specifications on the measures were not provided so we were unable to do a complete assessment of all of the measures. So we ask CMS to also look at these measures with the criteria that we laid out in the comment letter.

We do not support the inclusion of the following measures as these are not high priority measures for consumers and purchasers; this list is not exhaustive:

- M14 - Coronary Artery Disease (CAD): Symptom Management. This measure does not require that the results of the evaluation be reported. We are also concerned that this measure provides physicians with a “pass” for simply having documented a plan of care for achieving control of angina symptoms even when the outcomes are poor. This measure also appears duplicative of PQRS 2011 measure 196 (Coronary Artery Disease: Symptom and Activity Assessment). Allowing physicians to receive a bonus for reporting on such similar measures is not appropriate. Additionally, the denominator of M14 only includes patients who have had an evaluation completed. This raises the question of whether all patients who required an evaluation received an evaluation.
- M13 – Coronary Artery Disease (CAD): Blood Pressure Control. Whether or not the patient achieved blood pressure control should be measured and reported separately from whether or not a prescription was written. Currently there are standard HEDIS measures for both blood pressure and lipid control and in the United Kingdom, physicians are already reporting whether patients have achieved blood pressure control as a standalone measure. As proposed, these measures could run the risk of going “backwards” – away from the agreed upon need to measure outcomes. As noted earlier in our comments we are also concerned that this measure will mask outcomes and allow physicians a “pass” for just prescribing medications even when the outcomes are poor. These comments also apply to measure M18 (Hypertension: Blood Pressure Control).
- M16 – Atrial fibrillation and Atrial flutter: Assessment of Thromboembolic Risk Factors. This is purely a documentation measure. Instead the results of the assessment should be reported.

- M20 – Preventive Care and Screening: Obesity Screening. This is purely a documentation measure. Instead the focus should be on capturing the results of the screening.
- M36 – Radical Prostatectomy Pathology Reporting. This is a documentation measure. It only requires that evaluation results were documented, not reported.
- M75 – Assessment of Thromboembolic Risk Factors: This is a documentation measure – the results of the assessment should be reported rather than just documented.
- M81 and M82 – COPD: Tobacco Use Screening, these tobacco cessation measures are “check box” measures that fail to assess the quality of the cessation counseling. An alternative would be to ask patients about the effectiveness of the counseling.