AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

January 19, 2011

Donald Berwick, M.D.
Administrator
Office of Clinical Standards and Quality
Centers for Medicare & Medicaid Services
Mail Stop S3–02–01
7500 Security Boulevard
Baltimore, MD 21244–1850
Email: Physician_Reporting_TEMP@cms.hhs.gov.

RE: 2012 Physician Quality Reporting System Town Hall Meeting Comments (CMS–3236–N)

Dear Dr. Berwick:

On behalf of the American Academy of Family Physicians (AAFP), which represents more than 97,600 family physicians and medical students nationwide, I am writing to offer our comments on the 2012 Physician Quality Reporting System (PQRS). AAFP appreciates the agency's proactive effort to seek multi-stakeholder input on the PQRS prior to the 2012 PQRS Town Hall meeting.

AAFP continues to be a longstanding supporter of quality improvement efforts. We share the agency's goal of increasing successful participation in the PQRS. This is particularly important since Sec. 3002 of the *Affordable Care Act* permits the agency to impose a payment penalty beginning in 2015 for physicians that do not satisfactorily submit data on PQRS quality measures.

Improved Feedback Reports

A simple yet essential method to increase successful PQRS participation is by dramatically improving access to PQRS feedback reports. The current system for PQRS feedback reports has not been timely or helpful. Delays in analysis and payment decisions have pushed reports out so far from the date of service (18 to 24 months) that they are not useful for quality improvement. We recommend that the system be redesigned to automatically generate a report as soon as reporting requirements have been satisfied. Data collection algorithms can be utilized to assure that the data is complete and correct before it is accepted. Once the required data has been submitted, the participant could see immediately on the online data entry screen that the task was complete. This is exactly what most registry systems do and why registries enjoy such a high level of successful completion.

More timely feedback to PQRS participants and their office staff could be achieved if CMS accepted measure rates directly from EHRs rather than just numerator and denominator data. Rates generated within the system will be more readily available for local quality improvement purposes.

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Phase out Claims Based Reporting

Since it was not designed to support quality reporting, claims-based reporting has been problematic from the start of the PQRS program. The complexity of the claims-based reporting system causes frequent reporting errors. The feedback loop for claims-based reporting is inordinately long and of little value for quality improvement or better patient care. As communicated in our comments on the 2011 proposed physician fee schedule, AAFP recommends that CMS phase out the claims-based reporting option.

CMS should focus educational efforts on increasing PQRS participation via registry-based reporting and EHR-based reporting. By comparing the abysmal success rate of PQRS participation through claims-based reporting with the significantly higher success rates of participation through registry-based reporting and EHR-based reporting, it is clear that claims-based reporting must discontinue.

Expanded EHR-based reporting periods

For the 2011 PQRS, CMS offers full and half year reporting periods for claims-based and registry-based reporting, yet curiously the half year reporting period is not offered for EHR-based reporting. We recommend that the reporting period for EHR-based reporting be expanded to the same two options as the other methods of reporting. The additional reporting periods were instituted to increase participation rates in a new and evolving program. Physicians who implement EHR-based reporting after January 1 but before July 1 should be able to take advantage of incentives in the same manner as the other reporting methods.

Increased alignment between the PQRS and the EHR Incentive Program

AAFP favors alignment of clinical quality measures between these two programs. Quality measure reporting is one of the requirements of the EHR incentive program and we believe PQRS measures should satisfy that objective. However, PQRS incentives should not require participation in the EHR incentive program and vice versa.

Conclusion

CMS should place greater emphasis on the quality of patient care and less on forcing physicians to jump through administratively challenging hoops in order to earn a financial incentive or avoid a payment reduction. AAFP looks forward to future opportunities to comment as the agency further develops the 2012. If we may be of further assistance on this, please contact Bruce Bagley, M.D., the medical director for quality improvement. He can be reached at 913-906-6000 ext. 4120 or by email at bbagley@aafp.org.

Sincerely,

Lori J. Heim, MD, FAAFP
Board Chair