August 26, 2011

Dr. Donald Berwick, Director
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Dr. Berwick:

Thank you for the opportunity to comment on the 2012 proposed rules for physician payment under Medicare. NCQA appreciates the challenge CMS faces in moving forward these important initiatives designed to improve the quality of physician care in Medicare. Medicare should take every opportunity to align with private sector and Medicaid initiatives to reinforce incentives and make it straightforward to participate in multiple initiatives to improve quality. With this as a goal, we recommend that:

- Physicians reporting through registries should allow reporting of quality scores on a sample drawn from all patients
- CMS should report on physician recognition earned through private sector initiatives on the Medicare Compare website
- CMS should encourage use of certified health risk appraisals in the annual wellness visit in Medicare by creating a process by which health risk appraisals certified by certain review programs are deemed to meet CMS requirements.

Use of all-payer sample for PQRS reporting

Until the most recent final rule, CMS permitted submission of quality measures from practices that reflected a broader sampling frame than Medicare only. NCQA has consistently advocated for the option of including non-Medicare patients in the sample frame to encourage participation in PQRS. Providers allowed to include all patients in their monitoring efforts are more effective at identifying opportunities for improvement. By reinstating the policy of allowing clinicians to include their private sector patients in the sample frame Medicare would benefit from continued participation of existing recognized clinicians in PQRS as well as expected increases we have seen in the past several years.

While we appreciate that the PQRS is a Medicare program, we believe it is in all of our interest for Medicare to align with private sector initiatives that promote reporting and improvement on quality. We recognize that eventually electronic medical records will be the principle vehicle through which physicians report quality measures.

NCQA’s clinician programs originated with a number of private sector initiatives to encourage physicians and other ambulatory care providers to be recognized for excellent performance in providing diabetes care, heart/stroke care, and care of low back pain. For each of these programs, NCQA requires clinicians to report on the quality provided to a statistically valid sample of patients, consistent with our belief that public reporting and assessment are cornerstones of excellence. To maximize the potential for adequate sample size and to reflect their general patient population, we have not required that the
sample be limited to Medicare patients. A strength of our program from the perspective of private payers and clinicians has been that they evaluate care provided to all patients across a practice.

To align efforts and increase the value of both NCQA’s Recognition Programs and PQRS, NCQA has served as a registry – reporting the quality measures that are reported to us as part of the recognition programs in turn to CMS. About 1,000 clinicians report measures through us and gain credit for participating in PQRS. These clinicians have been very satisfied with our support of the registry.

If CMS decides to continue with a Medicare-only sample, we recommend that the diabetes measure be expanded to include all patients below 75 years of age. This will increase sample size and reportable measures.

Physician Compare website

NCQA developed our clinician recognition programs together with national clinical and professional organizations as a way to distinguish excellent performance in clinical care. These are all voluntary programs now recognizing nearly 25,000 physicians nation-wide and growing rapidly. We have the following recognition programs:

- **Diabetes Recognition Program (DRP)**—NCQA developed this program to recognize physicians and other clinicians who use evidence-based measures and provide excellent care to their patients with diabetes. The DRP Program has 10 measures covering areas such as HbA1c control, Blood Pressure control, LDL control, Eye examinations, Nephropathy Assessment and Smoking status and cessation advice or treatment. The program is approved for registry reporting to qualify clinicians for the PQRS bonus. The program presently has about 10,000 Recognized clinicians.

- **Heart/Stroke Recognition Program (HSRP)**—NCQA developed this program to assess key quality performance measures that are based guidelines for secondary prevention of cardiovascular disease and stroke. Program measures include blood pressure control, complete lipid profile, cholesterol control, use of aspirin or another antithrombotic and smoking status and cessation advice or treatment. The program is approved for registry reporting to qualify clinicians for the PQRS bonus. Three thousand clinicians are recognized.

- **Back Pain Recognition Program (BPRP)**—This program recognizes physicians and chiropractors who deliver superior care to millions of Americans who suffer from low back pain. The program consists of 13 clinical measures and three structural standards such as the elements of the physical exam and advice for the return to normal activities. These requirements address the broad spectrum of low back pain and focus on underuse, misuse and overuse of treatment modalities. NCQA developed BPRP requirements from widely accepted medical evidence, with significant input from physician specialists and health plan and employer representatives. The program is approved for registry reporting to qualify clinicians for the PQRS bonus. Almost 200 clinicians are recognized.

- **Patient-Centered Medical Home**—The PPC®-PCMH™ program reflects the input of the American College of Physicians (ACP), American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP) and American Osteopathic Association (AOA) to assess
whether primary care practices are functioning as medical homes. Building on the joint principles developed by the primary care specialty societies through the Patient Centered Primary Care Collaborative, the standards emphasize the use of systematic, patient-centered, coordinated care management processes. The program is less than three years old, but recognizes nearly 12,000 clinicians in 2,500 practices.

- An earlier version of PCMH called Physician Practice Connections also recognizes excellence in care coordination and is open to clinicians who are not in primary care.

Many state and regional governmental health care agencies are sponsoring payment initiatives based on NCQA recognition programs. In addition, private insurance companies and employers offer increased reimbursement to our recognized clinicians through pay-for-quality programs. For example, several of the NCQA programs were adopted by the Bridges-to-Excellence organization to form the basis of its national pay-for-quality program. The NCQA recognition programs are among the most highly regarded achievement for clinicians in the area of quality and performance improvement.

The chart below shows the states that are directly using the NCQA program; others may have adapted our standards or allow NCQA recognition to qualify practices.


<table>
<thead>
<tr>
<th>State Initiative</th>
<th>Medical home standards</th>
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<tbody>
<tr>
<td>IowaCare Medical Home Model</td>
<td>NCQA or equivalent</td>
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<tr>
<td>Maine Patient-Centered Medical Home Pilot</td>
<td>NCQA with modifications</td>
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<tr>
<td>Maryland Patient Centered Medical Home Pilot</td>
<td>NCQA with modifications</td>
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<tr>
<td>Massachusetts Patient Centered Medical Home Initiative</td>
<td>NCQA with modifications</td>
</tr>
<tr>
<td>Michigan Primary Care Transformation Demonstration Project</td>
<td>NCQA or BCBSM</td>
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<tr>
<td>New York Adirondack Medical Home Demonstration Project</td>
<td>NCQA with modifications</td>
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<tr>
<td>New York Medicaid Statewide Patient Centered Medical Home Demonstration Project</td>
<td>NCQA</td>
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<tr>
<td>North Carolina Community Care of North Carolina</td>
<td>NCQA</td>
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<tr>
<td>Pennsylvania Chronic Care Initiative</td>
<td>NCQA with modifications</td>
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<tr>
<td>Rhode Island Chronic Care Sustainability Initiative</td>
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<tr>
<td>Vermont Blueprint for Health</td>
<td>NCQA</td>
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<tr>
<td>West Virginia Medical Home Performance Incentive Pilot</td>
<td>NCQA</td>
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NCQA now makes information on recognition available on our website in a directory, but it would be more useful for consumers to have this information available with all the other information you plan to make available on practitioners on CMS’s Physician Compare site. Now that you are planning to include links to specialty board websites to provide information on board certification status on Medicare Physician Compare, we would ask you do the same for our recognition programs. We would be happy to provide descriptions of the different programs to you and to be made available on the site or to provide the link for you.
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Use of Certified Health Risk Assessment Tools as Part of the Annual Wellness Visit

CMS has laid out a reasonable set of criteria that describe elements of a health risk assessment that is to be used as part of the annual wellness visit. In order to simplify appropriate use of this tool for physicians, NCQA recommends that CMS identify which tools meet the criteria. Private organizations can review these tools and provide evidence certification that they meet the CMS criteria.

Over time, CMS should consider how to integrate data gathered through the health risk assessment with other elements of physician practice, including electronic health records. In our own Wellness and Health Promotion program, we have developed quality measures that flow from the data collected from the health risk assessment. Innovative health plans like Group Health Cooperative of Puget Sound have been pioneers in actively using information from the HRA to target focused clinical attention and action for patients at high risk.

Proposed 2012 PQRS Measures

We support CMS’s proposal to retain all of the 2011 PQRS measures, as well as incorporating the remaining 31 Medicare EHR Incentive Program measures into PQRS for 2012, and agree that program consistency and measure stability and alignment are important criteria. The addition of 26 new measures is appropriate, and we support consideration of measures that may either be in the process of NQF endorsement or adopted by CMS under the exception to NQF endorsement provision. It will be important to track use of measures over time and examine the penetration of measures of clinical outcomes vs. measures of process, with an eye towards prioritizing those measures that drive quality and provide demonstrable value to patients.

Aligning Incentives

Finally, we recommend that you to seek ways to align incentives across all of the CMS initiatives targeted toward physicians. We support the pilot to align Medicare meaningful use and PQRS reporting incentives. Ideally you would explore how this can be linked to e-prescribing and maintenance of certification as well. We would urge you to create straightforward paths for physicians and other practitioners – in groups and in small practices – to be able to earn the incentives when they have made strides in practice transformation that improve quality. Unlike health plans or hospitals, physician practices often have limited resources for complex administrative requirements. Aligning Medicare initiatives would be an important first step – then moving to align with Medicaid and private sector initiatives would be ideal. We recognize that in some cases you may need to ask for statutory flexibility to allow this to occur.

We would be pleased to discuss any of these issues further. Please do not hesitate to contact me or Sarah Thomas at Thomas@ncqa.org.

Sincerely,

Margaret E. O’Kane
President