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Dear Dr. Mostashari,

The Quality Measure Work Group members have developed several recommendations and comments to communicate to the Health IT Policy Committee and eventually to the Centers for Medicare & Medicaid Services (CMS) in response to the recently released Notice of Proposed Rule Making (NPRM) for the Electronic Health Record (EHR) Incentive Program. In the discussion below, we outline these recommendations and offer support for portions of the NPRM that we anticipate will encourage effective achievement of CMS's objectives with this incentive program for eligible professionals (EPs) and hospitals (EHs).

**QUALITY MEASURE WORK GROUP RECOMMENDATIONS:**

**RECOMMENDATION 1. CONTINUE PROGRESS TOWARDS OUTCOME MEASURES AND QMWG SUPPORTED CONCEPTS**



In March 2011 the QMWG identified 5 high priority domains (later reorganized to six domains) and 23 measure concepts for consideration in Stage 2 MU. These domains were all addressed in the February 2012 NPRM and many of the QMWG recommended measure concepts are under development as well. After comparing the 2011 recommendations of the QMWG to the EP and EH measure list, the workgroup reports the following:

- All 5 original domains have at least one concept that is fully represented (an NPRM measure closely extends the intention of the recommended concept) in a Stage 2 NPRM measure.
- All 5 domains also have both a fully represented and at least one partially represented concept in a Stage 2 NPRM measure.
- The NPRM reflects efforts to drive innovation in e-measurement. For three domains, Population/Public Health, Care Coordination, Patient Safety, the Stage 2 NPRM includes measures that the WG suggested for *Stage 3* MU (such as Longitudinal Improvement in Blood Pressure).
- The Clinical Appropriateness and Population and Public Health domains have the complete coverage and also contain a plurality of the NPRM measures that represent 2011 WG concepts.

- From the WG perspective, Care Coordination is the domain at greatest risk. Of the 5 Care Coordination measure concepts that the WG recommended only one is fully represented and one is partially represented. The sub-domain Effective Care Planning has no measure representation in Stage 2 MU.
- The sub-domain Honoring Patient Preferences and Shared Decision Making is a high value area that the WG recommended be addressed in Stage 3. The WG would like to reaffirm our interest in shared decision-making and strongly supports the adoption of measures for Stage 3 that address our previously described measure concepts.
- Individual measures sub-recommendations
  - ***Recommendation 1.1. Falls risk screening. The QMWG recommends a broader measurement of falls risk that captures risk across care settings.***
    - There is no inpatient CQM that addresses fall risk, but hospitalized patients and recently discharged patients are at especially high risk for falls.
  - ***Recommendation 1.2. Closing the referral loop. The QMWG recommends low thresholds for the referral loop measure.***
    - Since this is a *de novo* measure and one that will be challenging to consistently capture, the QMWG recommends low thresholds.
  - ***Recommendation 1.3. Medication Reconciliation. The QMWG recommends a wider age band for Medication Reconciliation.***
    - This measure proposed in the NPRM only tracks medication reconciliation for patients older than age 65. Medication reconciliation should be encouraged in all patients, regardless of age.
  - ***Recommendation 1.4. ADE Prevention & Monitoring. The QMWG recommends clarity for the type of medication and monitoring tracked by this measure. The WG recommends warfarin as the measured drug and INR as the monitored test.***
    - The measure description is currently vague in its description of what drug will be the measure target and which tests results should be monitored.
  - ***Recommendation 1.5. Eliminate "Check-box" Compliance. NQF 407 HIV/AIDS and Potent ART.***
    - This measure bases the presence of HAART on a single provider attestation that provider has placed a patient on HAART.

## RECOMMENDATION 2. CONTINUE ALIGNMENT OF MEASURES ACROSS PROGRAMS

To encourage provider adoption, reduce administrative burden, and encourage focused improvement, CMS should continue to align measures across its family of measurement and payment programs. MU 1 was challenging for small practices; CMS should appreciate the extent to which increasing requirements can be barriers for MU2. Just as federal programs are aligning to drive payment for value, measurement alignment should facilitate new payment and policy priorities.

- Alignment is worthy goal, but policy programs should not align in a manner that increases provider burden or compromises the credibility of CQMs – especially if it is based on pre-EHR technologies.
- As federal programs are aligning to drive payment for value, measurement alignment should facilitate new payment and policy priorities
- The QMWG strongly encourages alignment of patient safety across care settings- EH, EP and potentially others like LTCs.
- Mapping across reporting programs is desirable for alignment but must be clear and specific –
- Sub-recommendations
  - ***Recommendation 2.1 Allow MU qualification to satisfy PQRS requirements:***
    - P 13748 of the proposed rule suggests “Medicare EPs who submit and satisfactorily report Physician Quality Reporting System clinical quality measures under the Physician Quality Reporting System’s EHR reporting option using Certified EHR Technology would satisfy their clinical quality measures reporting requirement under the Medicare EHR Incentive Program.” We encourage CMS to reverse this option, so that EPs who fully satisfy the meaningful use requirements may be deemed to have satisfied the PQRS requirements. We do not believe that satisfying the PQRS requirements provides an indication of “meaningful use” that would qualify for incentive payments.
  - ***Recommendation 2.2. CMS should extend patient care settings beyond EPs and EHRs to facilities involved in long-term care.***
    - Providers who can demonstrate effective care coordination with long-term care, home health, or other providers who are using standards-compliant EHR technology (but not eligible for EHR Incentive Program) should be given credit for satisfying the care coordination criterion.  

## RECOMMENDATION 3. CONTINUE TO FOCUS ON SIX QUALITY DOMAINS WHILE PURSUING A BALANCED APPROACH

The WG supports the six reporting domains listed in the NPRM. These domains were previously described as high priorities in the August 2011 Health Information Technology Policy Committee (HITPC)/Quality Measures Workgroup Transmittal Letter in accordance with the National Priorities

Partnership and National Quality Strategy. To support clinical focus on these six domains, the QMWG favors option 1a for EPs quality measure reporting.

- Sub-recommendations
  - ***Recommendation 3.1 Reporting option: Select 1a as the process for individual EP reporting***
    - The QMWG suggests that the 1a option be required for individuals and the 1b option required for group reporting.
  - ***? Recommendation 3.2. Reporting option: Require individual EPs to report as few as X measures.***
    - The QMWG recognizes the many specialist and subspecialists will confront a significant challenge of choosing a dozen measures from 6 domains that are relevant to their practice, even from the 125 measures. The QMWG also appreciates that the number of measures in the final rule will likely be significantly reduced from the 125 proposed. We are confident that internists, family medicine physicians and geriatricians will find a variety of relevant measures and little challenge to the 12 measure requirement. After reviewing the measures, with a very generous assignment scheme, we found only 8 measures that were likely to be at least partially relevant to gastroenterologists.



#### **RECOMMENDATION 4. CREATE A PATH TO SIGNAL MU STAGE 3 INTENTIONS**

***Recommendation 4.0: CMS should advance its timetable for the release of future MU NPRMs or informational letters to announce CMS intentions and to allow adequate software design and development time for vendors and workflow planning for providers.***

CMS should consider an interim publication, following the FR of Stage 2 MU and preceding the Stage 3 MU NPRM. CMS should also consider advancing the release date for Stage 3 MU NPRM to allow vendors more time to develop the appropriate functionality and providers time to adjust applicable clinical workflows. To the extent that such a timetable switch is infeasible, the WG encourages CMS to send clear, strong signals through the Stage 2 MU FR this fall. Although the committee recognizes that CMS cannot make Stage 3 final decisions without experience from implementation of Stage 2, a clear signal of intentions would be very helpful to make vendor and provider implementation more feasible. Furthermore, the availability of measures to satisfy reporting domains remains weak and will need substantial attention for Stage 3. Data elements and data types needed for Stage 3 should be captured by Stage 2 certification.

## QUALITY MEASURE WORKGROUP COMMENTS ON NPRM STAGE 2 MU

### **Comment 1. Group reporting: Find means to appreciate individual provider variation**

In 2011 the HITPC recommended that a group reporting option allow provider groups to report for their EPs as a whole rather than broken out by individual EP. Group reporting meets CMS's goal of reducing both the administrative burden of reporting and encouraging high quality, team-based care. Whereas multi-fold variations in care quality and utilization persists in American medicine, the QMWG supports finding more efficient batch reporting options that do not obscure variability in the group.

However the QMWG has concerns that the group reporting option, as described in the NPRM, may allow "groups" of doctors that only share a tax ID to report together without them having coherent practice with care coordination. The WG suggests making the financial incentive align for "natural" groups like ACOs, but make the financial incentives stronger for "artificial" groups (e.g., multi-specialty group sharing a tax ID, but not exchanging data or doing care coordination) to report individually rather than as a group.

### **Comment 2. MAP: Do not discard CQMs that were "Not Supported" by MAP**

Many CQMs that were declared "Not Supported" by MAP are measures that have been identified as high priority by Federal advisory committees, support broad quality initiatives, and align with other CMS quality reporting programs.

As the QMWG supports reporting option 1a (allowing eligible providers to pick from a menu of measures across the 6 domains), QMWG encourages a robust number of measures to be included so that providers have a variety of options in each domain.

At the time of the MAP endorsement, the new measures were only measure concepts, without detailed numerator, denominators and exclusions; therefore the MAP could not make a fair evaluation. For this reason, the QMWG does not consider the lack of MAP support to be a fatal flaw for any CQM and recommends that novel measures be considered on their own merits, that is, their ability to describe and support quality care and to support a comprehensive set of CQMs.

### **Comment 3. CQM range: CQMs should cover a broad range of quality measurement**

QMWG enthusiastically supports the wide ranging list of 125 potential measures for EPs and 49 potential measures for eligible hospitals and CAHs. The Work Group that a broad number of measures continue to be options for providers- to provide meaningful measurement for a wide range of specialties and practices.

### **Comment 4. Quality measure selection should support a simplified vendor platform**



### **Comment 5. EH CQMs - EH required to report 15 CQMs in 2013**

The QMWG supports EH reporting 15 CQMs in 2013...

**Comment 6. EH CQMs - EH required to report 24 CQMs in 2014**

The QMWG supports EH reporting 24 CQMs in 2013...

**Comment 7. CQM threshold exceptions: Case threshold should apply equally to all hospitals**

In 2011 the HITPC recommended to limit the case threshold exception to children's hospitals, cancer hospitals and some Indian Health Service hospitals. The QMWG disagrees, the case threshold exception should apply equally to all hospitals regardless of hospital type...

**Comment 8. WG supports linkage between QMs and clinical decision support**

**Comment 9. Zero Scores: No longer allow zero scores**

**Final Comments**

- General endorsement for approach to hospital measures
- Debate between those who favor fewer measures likely to produce reliable, comparable results and those who favor large inventory of measures to address multiple specialties, induce platform improvements
- Extended discussion of criteria for reducing length of EP measures list – many diverse perspectives
- Need for tighter specifications, implementation guides to assure measures are robust enough to use and compare
- Cautious endorsement of group reporting option – for “meaningful groups”
  - Option 1b may be an approach to consider for Group Reporting only