AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

April 5, 2013

Marilyn Tavenner, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–3276–NC
Mail Stop S3–02–01
7500 Security Boulevard
Baltimore, MD 21244–1850

Re: Use of Clinical Quality Measures Reported Under the Physician Quality Reporting System, the Electronic Health Record Incentive Program, and Other Reporting Programs

Dear Administrator Tavenner:

On behalf of the American Academy of Family Physicians (AAFP), which represents more than 105,900 family physicians and medical students nationwide, I write in response to the request for information on the "Use of Clinical Quality Measures (CQMs) Reported Under the Physician Quality Reporting System (PQRS), the Electronic Health Record (EHR) Incentive Program, and Other Reporting Programs" that CMS published in the February 7, 2013 *Federal Register*.

The AAFP appreciates that CMS seeks input regarding ways in which:

- An eligible professional (EP) might use the CQM data reported to specialty boards, specialty societies, regional health care quality organizations, or other non-federal reporting programs to also report under the PQRS and EHR Incentive Program.
- The entities already collecting CQM data for other reporting programs might submit this data on behalf of EPs and group practices for reporting under the PQRS and the EHR Incentive Program.
- CMS can implement section 601(b) of the *American Taxpayer Relief Act* of 2012 which provides for treating an EP as satisfactorily reporting data on quality measures if the EP is participating in a qualified clinical data registry.

It is an AAFP principle for physician performance measurement that the purpose of performance measurement should be to identify opportunities to improve patient care so that these programs lead to better informed physicians and consumers. Our policy on electronic health records is such that we believe every family medicine practice should leverage health information technology, such as EHRs and related technologies needed to support the patient-centered medical home. These capabilities can support and enable optimal care coordination, continuity, and patient centeredness, resulting in safe, high-quality care and optimal health of patients, families, and communities.

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Our position on physician level clinical performance measures calls for our support for health care quality improvement endeavors used for local improvement efforts, public reporting, accountability, or pay for performance programs. The AAFP encourages the utilization of performance measures that are committed to promoting quality, cost-effective health care.

The AAFP is pleased to offer the following constructive feedback; our responses follow the questions that CMS posed in the request for information:

A1. How are the current reporting requirements for the PQRS and the reporting requirements in 2014 for the EHR Incentive Program similar to the reporting requirements already established for the ABMS boards or to other non-federal quality reporting programs? How are they different? In what ways are these reporting requirements duplicative and can these reporting programs be integrated to reduce reporting burden on eligible professionals?

Primary care physicians, since they treat such a diverse patient population, are challenged in their ability to successfully leverage clinical data for quality measurement and improvement purposes due to limitations imposed by EHR vendors. These vendor-limitations create unnecessary complexity for data extraction, measurement analyses, and submission. Many vendors claim to be meaningful use-compliant but in practice they do not produce the measures required by the PQRS or the EHR incentive programs.

Primary care physicians' PQRS and non-federal quality reporting efforts often are duplicative in nature, but can measure the same outcomes in different ways. Too often, these redundant requirements for data entry and abstraction do not align and are for small samples of patients rather than the practices' full patient population.

A2 Are there examples of other non- federal programs under which eligible professionals report quality measures data?

Several private insurance providers also administer quality improvement programs that require physicians to report data on quality measures. One example is the Bridges to Excellence programs.

Also, continuing medical education (CME) activities are increasingly developed so that analysis can be performed on gap and outcomes measures. The AAFP believes that pre- and post-analyses of CME related measures are an essential part of a lifelong learning program for physicians. These are increasingly aligned with Maintenance of Certification efforts and function as tools for clinical improvement. Consequently the AAFP advocates for a CMS recognition process for accrediting or certifying these activities as meeting PQRS requirements.

A3. What would be the benefits and shortcomings involved with allowing third-party entities to report quality data to CMS on behalf of physicians and other eligible professionals?

Allowing third-party entities to report data to CMS could assist in quality improvement efforts by generating larger amounts of data. The participation by these entities could assist medical practices, especially smaller ones, with quality improvement through assisted data extraction, broader benchmarking, and a better capacity for direct technical support.

However, non-standard data capturing techniques, balanced patient representation, and thoughtful analysis are potential shortcomings in allowing a third-party entity to participate in measurement reporting. Organizations that are focused on individual physician performance improvement throughout the quality improvement learning cycle are more

likely to prioritize accurate data acquisition and analysis than those less experienced organizations merely aiming to pass minimum requirements. The AAFP is separately concerned that some physicians might question a third-party's ability and confidentiality to send data to CMS.

A4.What entities have the capacity to report quality data similar to those reported under the PQRS, Value-based Payment Modifier, and/or EHR Incentive programs? If these entities were to report such data to CMS, what requirements should we include in the reporting system used by such entities, including requirements to ensure high quality data?

As CMS contemplates which entities have these capabilities, we urge CMS to closely adhere to our data stewardship guidelines that outline the appropriate collection, storage, transmission, analysis, and reporting of health data generated within a physician's office. Clinical quality measure developers should facilitate quality data collection, analysis, and reporting. Gathered data should then be used to refine the measure development process. Measures should be developed and implemented to improve the clinical discipline that the measures evaluate, rather than meeting an arbitrary reporting requirement imposed by either the quality improvement program or a vender data submission process. EHR and clinical registry vendors might potentially function as intermediaries and report quality data to CMS on behalf of participating physicians.

A5. How should our quality reporting programs change/evolve to reduce reporting burden on eligible professionals, while still receiving robust data on clinical quality?

The AAFP believes public and private quality reporting programs must first focus on individual physician improvement through the use of evidence-based and clinically relevant measures. Measurement and improvement should be the goal instead of overly fixating on reporting processes.

As noted in an AAFP article for members on registries, we believe that the use of fully integrated, point-of-care registries, distinct from other clinical registries, will not only reduce data collection burdens that practices experience daily but also will offer the opportunity to provide more reliable, consistent, and evidence-based care to patients with chronic conditions. Furthermore, the existence of a central database in which researchers and payers can pull data for various reasons would reduce the burden associated with researching quality improvement efforts. The AAFP emphasizes the need for EHRs that have the capacity to turn data into meaningful measures.

B1. What types of entities should be eligible to submit quality measures data on behalf of eligible professionals for PQRS and the EHR Incentive Program? Examples might include medical board registries, specialty society registries, regional quality collaboratives or other entities. What qualification requirements should be applicable to such entities?

CMS currently requires existing intermediaries to submit actual data including the patient identifiers to verify that the data submitted contains information on Medicare beneficiaries. The AAFP encourages CMS to deem other entities, such as an organization's certifying board for continued capacity to report on behalf of its physicians, to conduct this important verification prior to the submission of aggregated data to CMS.

B2. What functionalities should entities qualified to submit PQRS quality measures data possess? For example, for CQMs that can be electronically submitted and reported under PQRS and the EHR Incentive Program, should an entity's qualification to submit such measures be based on whether they have technology certified to ONC's certification criteria for CQM calculation and/or electronic submission?

The AAFP believes CMS should establish robust national standards to ensure all entities seeking to submit measurement data to CMS are qualified and capable of doing so. We also believe that CMS and ONC should continue to harmonize PQRS and meaningful use requirements. We again urge CMS to utilize our data stewardship principles.

B3. What criteria should we require of entities submitting quality measures data to us on behalf of eligible professionals? Examples might include transparency of measures available to EPs, specific frequency of feedback reports, tools to guide improvement efforts for EPs, ability to report aggregate data, agreement to data audits if requested, etc.

The AAFP is concerned that CMS could overly depend on the certification of specific technology products, and instead we encourage the pursuit of policies that foster an ongoing and flexible relationship with entities so that contractual agreements between practices and vendors surrounding quality reporting mechanisms can be more adaptive as benchmarks are achieved and quality improvement actually occurs.

B4.Should reporting entities be required to publicly post performance data?

The AAFP supports the continued use of Medicare's Physician Compare website and we do not support creating other public reporting options for Medicare data. We also urge CMS to reference the AAFP's physician performance reporting guiding principles. Our policy on transparency stipulates that reported data must easily be verified for accuracy. Both data and process should be transparent and include an explicit disclosure of data limitations.

B5.Should we require an entity to submit a yearly self-nomination statement to participate in PQRS?

The AAFP supports the initial use of a self-nomination process, though we encourage CMS to also develop longer term relationships with data/measure submitting partners.

B6.What should be included in the data validation plan for these reporting entities?

CMS should require these entities to plan for collection and submission of aggregate data while also using ad hoc manual audits as a required element of validation for data aggregation and analytics organizations. The plan should also require outlier monitoring and evaluation.

B7.If CMS provided a reporting option for PQRS and/or the EHR Incentive Program through such entities, what specification should CMS use to receive the quality data information (for example, Quality Reporting Document Architecture [QRDA] 1 or 3, XML, other)?

The AAFP urges CMS to offer multiple options for how raw data is handled so long as the final report for the individual physician is standardized and accurately reported on the Medicare Physician Compare website.

The AAFP urges CMS to clearly define the data specifications needed for the two specified programs, thus allowing for multiple submission formats. Not only are the data formats important, but the term sets used to represent the data values are critically relevant and need unambiguous definitions and consistent use. The AAFP encourages CMS to find an appropriate balance between interface terminologies, reference terminologies, and reporting terminologies.

B8.Should data submission timelines for these reporting entities be modified so that the submission timeframes for these quality reporting programs are aligned? For example, PQRS qualified registries are required to submit quality measures data once, within 2 months following

the reporting period. How much time are reporting entities outside of PQRS afforded to submit quality measures data? What challenges do reporting entities face in reporting data according to current timeframes?

The AAFP believes CMS should impose as much consistency with existing timeframes as possible. We believe quality data analysis should be performed every six months, at a minimum, but would be more beneficial in promoting improvement initiatives and evaluation of quality improvement interventions if performed on a quarterly basis. The AAFP also believes that physicians should be able to request ad hoc reports from the organizations they trust to collect, analyze, and protect clinical data from their practices.

B9. What oversight (for example, checks or audits) should be in place to ensure that data is submitted and calculated properly by entities?

The AAFP believes that standards must be established to ensure both data security and quality. CMS could then conduct a random audit on a sample of participating entities to ensure compliance. The AAFP also recommends that entities scrub the data at an early stage, before it reaches CMS. If inconsistencies or errors are identified, they must be remedied by the physician and reporting entity.

The AAFP also calls for an analysis of test data sets to be completed annually and with any major version changes to the data collection or analytics software.

C1.Should we require that a certain proportion of submitted measures have particular characteristics such as being NQF-endorsed or outcome-based?

The AAFP continues to support the required use of NQF-endorsed measures. Since the AAFP sponsors the creation of robust quality measures, family physicians and primary care providers in general encounter complex measures whereas those new to the PQRS might opt for easier measures.

Furthermore, measures should be created and clinically validated by organizations that define and support the medical specialty, and then followed by proper outside verification of the measure through an entity like the NQF. CMS should work with boards and specialty societies to establish and maintain a set of measures which support national health priorities and the clinical integrity of medical specialties and subspecialties.

C2.Should we require that the quality measures data submitted cover a certain number of the six national quality strategy domains?

The AAFP advises against this approach. We are concerned that there currently are not measures in each domain to draw on yet for all specialties. Since the six strategies relate to important national goals, the domains do not always translate directly to the physician or group level measurement.

C3.To what extent would third-party entities struggle to meet reporting for measures currently available under PQRS and EHR Incentive Program?

For the program to be successful, the AAFP believes that the measures should be able to be extracted from the EHR without additional effort on the part of the physician. Reporting a measure should not require additional data or be an additional burden because the information required for the measure is beyond information usually needed for the physician to make a treatment decision with the patient.

D1.If we propose revised criteria for satisfactory reporting under PQRS and for meeting the CQM component of meaningful use under the EHR Incentive Program, how many measures should an eligible professional be required to report to collect meaningful quality data? For example, for reporting periods occurring in 2014, eligible professionals using CEHRT must report 9 measures covering at least 3 domains to meet the criteria for satisfactory reporting for the 2014 PQRS incentive and meet the CQM component of achieving meaningful use for the EHR Incentive Program. (For more information see the EHR Incentive Program Stage 2 final rule (77 FR 54058) and the CY 2013 Medicare PFS final rule with comment period (77 FR 69192).) If we were to align reporting criteria with reporting requirements for other non-federal reporting programs, in future years, should we propose to require reporting on a different number of measures than what is currently required for the PQRS in 2013 and the EHR Incentive Program under the Stage 2 final rule or should the non-federal reporting programs align with CMS criteria?

The AAFP does not believe CMS should evaluate a program based solely on the number of clinical quality measures reported. Theoretically, reporting on a single, high quality, clinically appropriate measure could make more significant quality and cost improvements than multiple yet inadequate measures. Instead of focusing on how data is collected and reported, CMS could focus quality improvement programs on a few robust patient oriented outcome measures. These measures should be reported nationally and performance information should also be posted publically. At the local level, however, process measures should be primarily used to promote feedback and quality improvement guidance so that patient outcomes can be systematically and incrementally improved.

D2. For PQRS, should eligible professionals still be required to report quality measures data on a certain percentage of their applicable patients, such as 80 percent, for 2014 and subsequent years? Or, should we require that eligible professionals report on a certain minimum number of patients, such as 20, rather than a percentage?

Whether it is worthwhile to measure a small sample or a majority percentage depends on the goal of the program. For targeted quality improvement purposes for all patients with a particular condition, physicians utilizing a clinical registry should be able to easily and electronically report the required number of patients or percentage. Broad based outcomes, however, must be evaluated through population analysis rather than sampling.

We appreciate the opportunity to provide these comments and make ourselves available for any questions you might have or clarifications you might need. Please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org.

Sincerely,

Glen Stream, MD, MBI, FAAFP
Board Chair