TEXAS MEDICAL
ASSOCIATION

Physicians Caring for Texans

April 8, 2013

Marilyn Tavenner
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention CMS – 3276 - NC
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Medicare Program: Request for Information on the Use of Clinical Quality Measures
(CQMs) Reporting under the Physician Quality Reporting System (PQRS), the Electronic Health
Record (EHR) Incentive Program, and Other Reporting Programs

Dear Ms. Tavenner,

The Texas Medical Association (TMA) is a private, voluntary, nonprofit association of Texas
physicians and medical students. TMA was founded in 1853 to serve the people of Texas in
matters of medical care, prevention and cure of disease, and improvement of public health.
Today, our maxim continues in the same direction: "Physicians Caring for Texans." TMA's
diverse physician members practice in all fields of medicine.

On behalf of our more than 47,000 member physicians, the TMA appreciates this opportunity to
comment on the above referenced request for information regarding the use and reporting of
clinical quality measures.

Should you have any additional questions or need any further information, please do not hesitate
to contact me directly or contact Shannon Vogel at TMA at 512-370-1411.

Sincerely,

Joseph H. Schneider, MD, MBA
Chair, *ad hoc* Committee on Health Information Technology

Overarching Comments

TMA recommends that CMS require certified electronic health record (EHR) vendors be able to report clinical quality measures (CQMs) and PQRS directly to CMS as part of Stage 3 meaningful use certification.

Physicians who choose to not or cannot use EHRs should continue to have the option to report CQMs or PQRS through online registries that are accredited by CMS. Part of the accreditation process should ensure that the registries have workflow-friendly interfaces that report appropriately to CMS.

Section I A: Maintenance of Certification

A.   Physician Quality Reporting System (PQRS)

TMA encourages CMS to ensure that groups of more than 100 physicians can report through a registry whether it is EHR based or CMS qualified, by submitting three measures for at least 80 percent of cases. This allows options for reporting without restricting the vendor type.

CMS must remain cognizant of the cost physicians incur when using technology for reporting through a registry. Physicians with low Medicare volume are required to report PQRS or e-prescribing data do not get much return through the incentive. Many registries have an annual cost of $300 or more.

B.   The EHR Incentive Program

TMA encourages CMS to continue to align meaningful use and PQRS measures to reduce the redundancy and burden of reporting.

Section II: Request for Information

Q. 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?

A. The current requirements established by the 23 specialty boards established under ABMS all use quality metrics that are endorsed by National Quality Forum (NQF), PCPI, or are evidence based. However, the specific number and measures required for physicians to participate in PQRS, the EHR incentive program, and for their Maintenance of Certification are not aligned. For example, the PQRS diabetes reporting group requires eight measures, while the reporting requirements for the Diabetes Quality Module under the American Board of Internal Medicine requires additional measures to complete the module, while the EHR incentive program requires submission of nine clinical measures from at least three national strategy

domains. This leads to increased confusion and administrative burden.

The ABMS MOC programs provide physicians with a much larger selection of quality improvement options, some of which involve education or work flow/process changes that do not require EHR data measures. For example, one MOC quality program focuses on education and work flow changes to improve hand washing rates of clinicians before seeing patients. TMA believes ABMS should accept work done by physicians who meet CMS reporting requirements rather than requiring them to do both. There will be physicians who do not participate in CMS programs who will need to use MOC quality programs. Ideally, each qualified registry should offer reporting capabilities for all measures and programs to reduce reporting efforts. It becomes costly for physicians to bear the burden of the reporting expense when participating in multiple programs, some without incentives.

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

A. Yes. Some examples include:
- Bridges to Excellence
- National Committee on Quality Assurance (NCQA)
- Patient Center Medical Home projects
- Accountable Care Organizations

Q. 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?

A. The benefits of allowing third party entities include benefits such as simplification of data reporting and merging of data streams to reduce paperwork burden on physicians and data entities, creating a more efficient process. There may be some risk if third party entities are not validated by CMS to ensure data accuracy.

Q. 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?

A. Currently, commercial payers such as UnitedHealth Care, Aetna, and others have the capacity to report quality data. It is a fair request for CMS to require entities reporting to CMS to have a validation process ensuring the submission of high quality data.

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

A. The primary means of reducing quality while increasing robust data reporting is to push forward with ONC-certified standards for EHR data and common database definitions, interoperability, and general harmonization of EHR data standards. A standard format such as

the HL7 QRDA formats are helpful for small practices that lack in-house technical expertise required to extract and format data for submission from their EHR. CMS should strive to use measures that can be submitted in a QRDA format, and EHRs should be certified as able to capture the necessary data and format it in that manner for submission purposes.

The goal should be allowing automated collection and reporting of data through certified EHR technology, preventing additional physician work in preparing and sending quality data. The only work that should be needed from the provider is to verify the authorization of the entity collating the data. With robust EHR data standards, EHRs should be able to connect seamlessly with the reporting entity and allow data extraction in a way that preserves the patient's privacy and security. It also would be helpful to have comparable reporting requirements such as the number and type of measures needed for reporting, the number of patients needed, and the type of patients that qualify for reporting of a certain measure.

One strategy CMS may choose to consider is to delegate the selection and use of quality measures to each state. It would be advantageous to promote collaboration among payers, physicians and hospitals in each state to identify their key health problems that they want to improve and then select sets of quality measures that would have a meaningful impact on the quality of care within their state. The major payers, physician/medical society groups, and hospital organizations in an individual state will be able to leverage the use of CQMs to meet the unique needs of their state rather than meeting national goals that may not be as important within their unique population and geography.

Q. 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 collaborative or other entities. What qualification requirements should be applicable to such entities?

A. Some examples of entities which should be able to submit data on behalf of physicians for PQRS and the EHR incentive program include specialty societies certified as board-awarding specialty societies; state medical board registries; and ONC-certified EHRs or health information exchanges (HIEs). Physicians themselves should be allowed to collate and submit individually, with a statement regarding their personal preparation of the materials. A technology agent or a registry may also be allowed to collate and submit on behalf of physicians, provided they counter sign an affidavit certifying validation of the materials for submission.

Q. 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?

A. Physicians or their agent should be allowed to submit data, so long as it is in the format required by the reporting program, which should be aligned. The formatting should be allowed after the data is actually entered, which allows physicians not yet using an EHR to participate in quality reporting initiatives. It is important not to alienate physicians, who are still in short supply and serve vital interests of patient care, by requiring EHR participation.

The burden can be reduced by removing the claims-based G8553 coding requirement to avoid the e-prescribing penalty. Many physicians are reporting e-prescribing through the Meaningful Use program. The programs should be aligned for maximum efficiency.

Q. 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.

A. Transparency of measures available to physicians; ability to aggregate data submitted; agreement to data audits if requested by EPs and CMS; ability to de-identify data; HIPAA-compliance of data submission and security of data conduits, storage, and transit. Monthly feedback reports through an online portal allowing physicians to download and view their data through a common file format such as an excel file would be useful.

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

A.   TMA strongly opposes the posting of performance data. Since the primary purpose of EHR data collection and analysis is to improve care, use of the data in other ways will be prone to inherent flaws. Posting performance data that should actually be used to improve performance can too easily be misinterpreted or misused by those lacking knowledge about the source and meaning of the data.   Also, the same set of data can too easily be manipulated in different ways to make an entity look either good or bad.

CMS should remain aligned with the primary purpose of EHR data collection and analysis to improve the quality of care. In order to improve care, experts are in agreement that a blame-free environment is essential in order to address quality of care issues. The aviation industry improved passenger safety by engaging pilots in self-reporting of errors and dangerous conditions through an offer of immunity from sanctions. Hospital quality programs have also moved away from punitive environments where blame is assessed and placed on individuals. To more effectively improve quality they now create blame-free environments where the focus is on identifying and improving systems and processes that are root causes for most medical errors, adverse outcomes and potential adverse events.

There is a punitive nature to using EHR data to compare physicians or hospitals. Without a blame-free environment physicians will naturally be dis-incentivized to be transparent about quality improvement. Physicians will be dis-incentivized to report errors or even to enter data into their EHRs if they think it might be perceived poorly. Whatever value one may perceive as being gained by posting performance data will be negatively affected by the loss of a blame-free environment where quality performance improvements would have been more likely to occur.

CMS could instead become instrumental in facilitating quality improvement efforts at the national level by educating the public on how data is being used to improve quality of care rather than requiring entities to post performance data which may cause more long-term harm than short-term good.

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

A. EHR vendors and registries should self-nominate each year indicating they are a validated or certified participant. If CMS is asking about physicians and other providers, then no, that would become an additional burden to the practice.

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

A. Minimal audits suffice as a data validation plan for reporting entities.

Q. 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)?

A standard format such as the HL7 QRDA formats are helpful for small practices that lack in-house technical expertise required to extract and format data for submission from their EHR. CMS should strive to use measures that can be submitted in a QRDA format, and EHRs should be certified as able to capture the necessary data and format it in that manner for submission purposes.

The goal should be allowance of automated collection and reporting of data through certified EHR technology preventing additional physician work in preparing and sending quality data. The only work that should be needed from the provider is to verify the authorization of the entity collating the data. With robust EHR data standards, EHRs should be able to connect seamlessly with the reporting entity and allow data extraction in a way that preserves the patient's privacy and security. It would also be helpful to have comparable reporting requirements such as the number and type of measures needed for reporting, the number of patients needed, and the type of patients that qualify for reporting of a certain measure.

Q. 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?

A. TMA believes additional time may be needed in light of the increased number of Group Practice Reporting Option PQRS and Meaningful Use quality measures CMS implements each year. It is burdensome for practices to manipulate the EHR for data extraction annually.

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

A: A fair and transparent process that discloses up front the industry standards used, audit process, and selection criteria.

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

A. TMA believes the submitted measures should be NQF endorsed, and not outcome-based.

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

A. One strategy CMS may choose to consider is to delegate the selection and use of quality measures to each state.   It would be advantageous to promote collaboration among payers, physicians, and hospitals in each state to identify their key health problems that they want to improve and then select sets of quality measures that would have a meaningful impact on the quality of care within their state. The major payers, physician/medical society groups, and hospital organizations in an individual state will be able to leverage the use of CQMs to meet the unique needs of their state rather than meeting national goals that may not be as important within their unique population and geography.

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

TMA believes the lack of standardization of data fields and definitions within the ONC-certified EHR products, and the lack of standardization of HIEs is the main obstacle to such turnkey reporting. Other obstacles include privacy and security constraints and liabilities related to HIPAA and state-based privacy statues, many of which do not align well with HIPAA, nor do they have sufficient precedent in case litigation to assure participants that data submission through registries is legally assured.

Another area third-party entities struggle with is meeting CMS measures that track transitions of care and patient education materials.

Q. 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?

A. There is no magical number as this varies by specialty. CMS should seek guidance from various national specialty societies to determine number of measures to collect meaningful quality data.

Q. 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?

A. A percentage such as 80 percent is perhaps the most objective means and able to produce the most robust data. Hardship and exclusion criteria will always be applicable and should be part of the vetting of any quality reporting program because of the necessarily heterogeneous nature of health care delivery. TMA further recommends the CMS not increase the number of measures needed per patient.