hfma
healthcare financial management association

April 5, 2013

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 310G
Washington, DC 20201

Re: CMS-3276-NC
Medicare Program: 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

Dear Ms. Tavenner:

The Healthcare Financial Management Association (HFMA) would like to thank the Centers for Medicare & Medicaid Services (CMS) for the opportunity to comment on issues related to measuring and reporting physician quality.

HFMA is a professional organization of more than 39,000 individuals involved in various aspects of healthcare financial management. HFMA is committed to helping its members improve the management of healthcare delivery systems, comply with the numerous rules and regulations that govern the industry, and further the principles of administrative simplification.

Background

In 2008, HFMA convened a group of healthcare stakeholders representing payers, providers, employers, and patients to define the key principles that a reformed payment system must achieve. The group came to consensus around five key principles, which are discussed briefly below:[1]

- **Quality:** Payments should encourage and reward high-quality care and discourage medical errors and ineffective care. Wherever possible, payments should reward positive outcomes, rather than adherence to processes. In the absence of outcome measures, payment systems should reward the use of accepted practice and evidence-based processes and protocols that meet or exceed standards of quality and safety to promote optimal outcomes. Payers should not be responsible for payment to cover costs directly related to serious preventable medical errors.

[1] Healthcare Financial Management Association, *Healthcare Payment Reform – From Principles to Action*, September 2008

- **Alignment:** Payments should align incentives among all stakeholders to maximize the efficiency and coordination of health services based on accepted practice and evidence-based delivery models and protocols. Payment systems should stimulate and reward healthful behavioral choices and selection of value-based services by consumers related to prevention, primary care, acute care, and chronic disease management. Care decisions should be made through a shared decision-making process in which patients' values and preferences are identified and respected.

- **Fairness/Sustainability:** Payment systems should balance the needs and concerns of all stakeholders. Payments should recognize appropriate total costs for the efficient delivery of healthcare services that are necessary and consistent with evidence-based care, high-quality/low-cost provider benchmarks, and the advancement of medical science. Payment systems should accommodate payers' and purchasers' needs to allocate funds in a predictable, manageable fashion. In addition, consumers should have financial incentive to select high-quality, efficient care without being discouraged from seeking necessary and appropriate services. Finally, the payment system should be sustainable, providing a stable funding stream in the face of competing claims on public and private capital.

- **Simplification:** Payment processes should be simplified, standard, and transparent. All parties should use payment methodologies, standardized at the national level, to reduce complexity. The payment methodologies should be transparent to those affected by them, and comply with privacy, security, and antitrust laws and regulations.

- **Societal Benefit:** The resources needed to support broad societal benefits (i.e. medical education and research, indigent care) should be paid for explicitly. Similarly, payment systems should reward innovators who develop technologies, services, processes, and procedures that enhance safe, high-quality, and efficient care.

Introduction

HFMA applauds CMS's interest in simplifying requirements for physician quality reporting and harmonizing these activities with non-federal programs where possible. We strongly support this effort as it provides an opportunity to better align CMS policy with three of our core payment reform principles: Quality, Alignment, and Simplification.

As such, we have solicited feedback from our members – who represent physician practices, hospitals and health systems, and payers – to respond to CMS's questions on this important issue. Based on the comments we received from our members, HFMA has identified two key principles that should guide CMS's efforts on quality reporting:

- CMS should work to harmonize reporting requirements across payment systems and programs to reduce redundant requirements, align financial incentives across provider types, and – most importantly – eliminate silos of care, which will lead to improved patient outcomes.
- As CMS harmonizes reporting requirements, it should ensure that there is as much flexibility as possible in reporting mechanisms to reduce providers' administrative burden.

Below please find HFMA's responses on CMS's specific questions.

1) 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 American Board of Medical Specialties 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?

   Both public and private payers have developed various quality reporting requirements that are reported through various submission mechanisms or claims-based measures to support initiatives such as quality report cards, medical homes, and other pay-for-performance programs.

   One of the findings from our Value Project research indicates that 55 percent of our members believe that quality measures are inconsistently defined across the various public and private payers. The likelihood that a provider reports inconsistently defined quality metrics appears to be positively correlated to the amount of revenue at risk under value-based reimbursement arrangements.

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

   a) *Payers collect quality metrics which are often based on NCQA or HEDIS criteria. However, in many instances, payers will adjust or make changes to measures to accommodate an internal need. For example, they may use different age criteria or different exclusion criteria.*

   b) *Clinical integration programs within individual health systems also use quality metrics. Typically these are based on HEDIS criteria (primarily) and on metrics developed by NQF, NCQA, or even self developed (as needed). The self-developed metrics are primarily for specialties where a lack of developed quality metrics exists.*

   c) *Physician data is included in state and federal hospital-submitted registries that could ultimately be sources for physician-level data reporting (e.g. ACC/NCDR, STS, NSQIP, etc.)*

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

   HFMA strongly believes that any changes to CMS's quality reporting programs should be underpinned by the following payment reform principles. A framework for evaluating potential changes should include the following:

Quality: Nationally recognized/developed measures should be the common metrics used by all entities required to submit data (physicians/other professionals, hospitals, nursing homes, home health). The lack of alignment creates silos of care across the continuum, focusing the effort of each individual entity on the differing areas that they are required to report on.

Alignment: Efficiencies should be pursued in the expanding scope and depth of reporting initiatives. It may not be necessary, for example, for physicians to report compliance in Antibiotic Selection if physician-identification can be extracted from the feed of data already received from hospital submissions on the same metric. Conversely, it may not be necessary for hospitals to submit data on compliance with diabetic teaching/follow-up if the same data is being submitted in the physician reporting program.

Simplification: Quality data should be able to be collected electronically in the normal course of business to support focused and real-time interventions. Use of EMR data flowing or extracted to registries, or similar systems, from which data can be provided to those requesting the data should be a focus. This will also help support lessening the growing data collection burden that exists today.

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

HFMA believes all measures should be fully vetted and endorsed by NQF or another nationally recognized accrediting body. In addition, all measures should include detailed specifications, including exclusion criteria. There are a handful of examples of hospital-focused quality metrics, where measures were quickly retired or suspended after initial release. This hindered focused improvement on patient care issues.

These endorsements cultivate acceptance of the measures and promote multilateral improvements that enhance patient care. Outcome-based measures are best suited to achieving the desired goal of improving patient quality. However, process-based measures can also be useful if they support analysis of the best practice initiatives that drive change to achieve desired patient outcomes.

Care also needs to be taken to ensure measures approved by NQF or other accrediting bodies are not changed (either purposefully or inadvertently) as a result of CMS's data extraction rules that are developed by CMS and often accompany the measure when it is sent out. This is a challenge we're hearing in particular from our members who are participating in the Medicare Shared Savings Program. When CMS has their weekly calls they change the measure by changing the abstracting rules but don't acknowledge that the measure is actually changed.

5) 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.

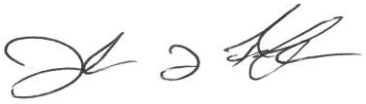
If we were to align reporting criteria with reporting requirements for other non-federal reporting programs, in future years, should we propose to require reporting on a different number of measures than what is currently required for the PQRS in 2013 and the EHR Incentive Program under the Stage 2 final rule or should the non-federal reporting programs align with CMS criteria?

As we stated in our introductory principles, we believe that the CMS quality reporting programs should retain enough flexibility to ensure that all providers can participate and do so with as little administrative burden as possible. Therefore, we do not recommend a set number of quality measures. The number should vary by specialty, as there are many more measures available to measure the quality of primary care than other specialties.

Further, until the vast majority of physicians are using EMRs from which data can be extracted, a balance should be struck between the number of measures and the burden of collection. Once data can be extracted from EMRs the number of measures can greatly increase with little additional data collection burden.

We are at your service to help CMS gain a balanced perspective on this complex issue. If you have additional questions, you may reach me or Richard Gundling, Vice President of HFMA's Washington, DC, office, at (202) 296-2920. The Association and I look forward to working with you.

Sincerely,



Joseph J. Fifer, FHFMA, CPA
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About HFMA

The Healthcare Financial Management Association (HFMA) provides the resources healthcare organizations need to achieve sound fiscal health in order to provide excellent patient care. With more than 39,000 members, HFMA is the nation's leading membership organization of healthcare finance executives and leaders. HFMA helps its members achieve results by providing education, analysis, and guidance, and creating practical tools and solutions that optimize financial management. The organization is a respected and innovative thought leader on top trends and challenges facing the healthcare finance industry. From addressing capital access to improved patient care to technology advancement, HFMA is the indispensable resource for healthcare finance.