

## **Recommendations to Align CMS Incentive Programs**

To align incentive programs (EHR Meaningful Use Incentive Program, Physician Quality Reporting System (PQRS), e-Prescribing), it is critical that the Centers for Medicare and Medicaid Services (CMS) undertake short and long term efforts. To facilitate alignment, this document provides recommendations on how to harmonize provisions and requirements across and within programs and reduce the burden of participation on practitioners. These recommendations reflect input from the American Medical Association (AMA), as well as medical specialty societies.

### **Current Challenges**

#### ***Misalignment induces duplication of effort and burden***

- Many of the same measures are in the PQRS and EHR Incentive programs. However, due to differences in reporting requirements, a physician must go through two separate reporting processes to report on the same measure for the PQRS and EHR Incentive programs. Therefore, data collection and quality measurement for physicians is unnecessarily burdensome and duplicative.

#### ***Underrepresentation of measure topics limits broad physician participation***

- Some specialties do not have relevant measures in the PQRS or EHR Incentive programs. Therefore, broad participation across specialty groups is limited.

#### ***Incongruent timelines impact program effectiveness***

- Lack of timely feedback and bonus payments is an on-going concern for physicians.
- Time constraints that relate to National Quality Forum (NQF) endorsement cycles and criteria, as well as CMS deadlines for measure consideration present a challenge in getting the optimum measures into the programs, and on a timely basis.
- Validating PQRS data results (when CMS results do not match a practice's records) should evolve from the current time consuming and cumbersome effort to a more efficient and user-friendly process.

### **Goals for Alignment**

#### ***Alignment of CMS program and reporting requirements should support three primary goals:***

1. Enhance the value of measurement as a strategy for performance improvement
2. Lower the burden of data collection activities associated with physician measurement and increase the efficiency of physician measurement across programs
3. Enable participation of all specialty groups

We have developed the following recommendations to achieve these goals:

### **Short Term Recommendations**

#### ***Robust Alignment***

- ***Complete alignment of the PQRS EHR option and EHR Meaningful Use Incentive Program:***
  - Measures and measure specifications
  - Reporting requirements (submission of data to CMS vs. measure calculations with certified EHR technology)
  - Reporting periods and timelines (currently PQRS: 6-month/12-month periods; EHR Incentive Program: 90-days + 12-month option)

- Allow group reporting under the EHR Incentive Program since the PQRS program has two group reporting options. This option reduces the burden for large multispecialty practices.
- **Promote EHR reporting.** To promote EHR reporting, measures developed for the EHR (EHR as the data source) should only be added to the PQRS program if they are also able to be added to the EHR Incentive Use program.
- **Add new measures to PQRS judiciously.** New measures for PQRS claims-based reporting should only be added when a specialty does not currently have sufficient measures to report in the program. Moreover, as new measures are developed within a clinical domain or measure concept category, it is important to think about developing a measure for EHR reporting first (as opposed to focusing on a claims-based measure).
- **Align implementation and reporting rules of PQRS and EHR Incentive programs.** CMS should work to align the implementation and reporting rules of the PQRS and EHR incentive programs. For example, we recommend an equivalent patient sample size for measures that are in both programs and that there should be parity with respect to the use of zero denominators in each program.
- **Implement a common data submission pathway to a central repository.** Use of common pathway for centralized reporting and submission of data to both programs is essential for alignment.
- **Synchronize CMS measure consideration timeline and NQF endorsement cycle.**

#### **Other Important Issues**

- **Improve the timeliness of feedback and bonus payments to participants and aggregate feedback reports to the AMA and specialty societies.** Not only should feedback reports be available in a timely manner, but the process for acquiring the reports must be relatively effortless for physicians and their practices. This feedback should include a breakdown by specialty of which physicians are reporting measures through claims, EHR, and/or registry.
- **Provide complete and constructive measure recommendations.** It is important to appreciate the intrinsic differences in measures developed for claims reporting and those developed for reporting from an EHR. Consequently, a claims based reporting measure cannot necessarily be re-purposed for EHR reporting and vice versa. It is important that measure developers make recommendations for not just measures but also the suggested data source from which the measures are to be reported. This is critical to ensure that measures that are truly appropriate for use in EHRs are specified for reporting via an EHR.
- **Identify a standardized set of data elements that match the information needs for each specialty.** Standardized data elements are essential to facilitate structured data capture by EHRs or other clinical applications to clearly collect and report performance measure data. The effort of developing a standardized approach for defining data elements is primarily the responsibility of measure developers and funding is needed to ensure effective standardization. The AMA convened Physician Consortium for Performance Improvement (AMA-PCPI) is well positioned to lead this effort.
- **Fund efforts to identify common measures across multiple specialties.** Care transition measures and patient reported outcomes are examples of important priority.
- **Ensure that clinically relevant measures are available for all physician specialties.** Specifically, there are specialties with sub-specialties (urology, radiology, nephrology etc.) that do not have clinically relevant measures for reporting. This is particularly true for the EHR Incentive Program.
- **Provide education for incentive program participants.** Participants must be able to distinctly interpret program provisions and reporting requirements for each program.
- **Retain claims reporting to ensure all physician practices have the opportunity to participate in incentive programs.** Claims reporting continues to be an affordable option for many

practices. Therefore, the PQRS should not transition completely away from claims until a financially viable option is available for all practices. Further, not all clinical data are currently available in an EHR. For example, some lab data or hospital information may not yet be in the EHR. Therefore, to report those measures, claims or registry reporting is necessary.

### **Long Term Recommendations**

There is an opportunity for creative thinking regarding the long term strategy for alignment of the CMS incentive programs. Section 3002 of the Affordable Care Act, which requires development of a plan to integrate physician quality reporting and EHR reporting, includes language allowing the Secretary discretion in achieving such integration. Specifically, this language provides that integration of the PQRS and EHR Incentive Programs must consist of certain factors set forth in section 3002, along with “such other activities as specified by the Secretary.” This clause allows flexibility in what may be built in to future rulemaking. It is from this perspective that we offer the following long term recommendations:

- Develop and implement a transition framework from PQRS claims to PQRS EHR, PQRS registry and EHR Incentive Program, as EHR functionality matures.
- Create a single rulemaking process across both programs (coordinated measure updates, aligned decision-making process, etc.)
- Consolidate the programs into a single program.
- Match measures to national priorities for improvement.
- Create a single set of audit criteria and validation processes that support timely feedback.
- Expand alignment objectives beyond the CMS programs by ensuring that the same measures and specifications can be implemented in board maintenance of certification programs.
- Align quality measurement in other government programs including, but not limited to, Medicaid and SCHIP. Encourage use of these measures by private payers.
- Harmonize measures across sites of care.
- Education for program participants.

### **Specialty Specific Concerns**

#### ***PQRS***

- Today, several physician specialties are not able to report on PQRS measures. These include, but are not limited to, interventional nephrologists; hospitalists; radiologists (which practice by modality or body system); physical medicine and rehabilitation; pathologists; non-diabetes/non-bone endocrinology; intensivists/critical care; gastroenterologist specializing in upper endoscopy; neurosurgery; ENT surgery; orthopedic surgery; bariatric surgery; other surgical subspecialties (especially in the ambulatory setting); sleep medicine; urology; and pediatric subspecialties (important for Medicaid EHR Incentive Program).
- Many physician specialists have expressed interest in CMS expanding the number of PQRS measure groups. Measure groups are closer to the concept of dashboards of measures that may be more useful in quality improvement efforts than a single measure or two within a clinical area. However, getting measures into CMS programs is hampered by the lengthy process involved with NQF endorsement cycles and CMS deadlines for measure consideration as outlined above.
- NQF recently announced two changes that will further lengthen the process of NQF endorsement including the requirement that measures have testing data before they are reviewed by NQF, and the combining of new measure evaluation with measure maintenance assessments on a 3 year timetable by system topic. Therefore, if a measure is not ready for

NQF endorsement consideration when the call for measures for a specific disease is scheduled, it will be three years before the opportunity will arise again.

- Several specialties recommend that physicians receive PQRS credit for participating in a registry that targets quality improvement or have engaged in quality improvement efforts through satisfying board maintenance of certification programs.
- Nuclear medicine physicians have one measure in the PQRS; however, it has a time-limited NQF endorsement, and therefore this measure may not be available in the near future because testing results do not meet NQF deadlines. Most nuclear medicine physicians do not participate in PQRS because it is too costly, and only the claims data reporting modality is available to them.
- Many clinical oncologists cannot report to PQRS using measures groups, an option that facilitates registry reporting and improvement activities. Increased measures group reporting would increase participation in PQRS. CMS rejected several measures groups submitted by physician specialty societies during the last physician fee schedule rulemaking process.
- Sleep medicine physicians currently cannot report sleep-related measures under the PQRS. There are four measures pending approval by CMS. If these measures are not included in the upcoming proposed and final rules, sleep medicine physicians will not have any PQRS measures. Unless a sleep medicine physician provides a significant number of non-sleep related services, he/she will not be able to participate in the PQRS.
- Allergy and asthma specialists do not have clinically relevant measures under the PQRS. New asthma measures have age limits, and therefore are not applicable to the Medicare population.

#### ***EHR Meaningful Use Incentive Program***

- A lack of clinical relevance for some specialties of the core, alternate core, and the remaining Stage 1 MU measures, coupled with accessibility issues with EHR systems, makes it very difficult for several physician specialties to meaningfully participate in this program. This includes nephrologists; urologists; radiologists; non-diabetes/non-bone endocrinology; intensivists/critical care; upper endoscopy measures; neurosurgery; ENT surgery; orthopedic surgery; pediatric subspecialties (important for Medicaid EHR Incentives); weight loss surgery; sleep medicine; urology; and additional surgical subspecialties (especially in the ambulatory setting).
- Standardization of data elements in EHRs is critical and physician specialty organizations must be involved to ensure data elements are clinically useful. The AMA convened PCPI has provided leadership in this area and will continue to work with physicians, standards organizations and stakeholders to ensure data elements are developed in accordance with physician and EHR requirements.
- Asthma and allergy physicians who are investing in certified EHR systems are finding that the measures currently included in the EHR Incentive program quality measures sets are not yet reportable through their CCHIT certified EHRs.
- Despite efforts by the physician community to work with vendors to adopt appropriate data elements for condition-related information, vendors have been unresponsive because some of the measures only apply to a small number of physician sub-specialists.