wellcentive

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Andy Slavitt
Centers for Medicare & Medicaid Services

Wellcentive comment,

Request for Information: Certification Frequency and Requirements for the Reporting of Quality Measures under CMS Programs

Director Slavitt and staff,

For more than a decade, Wellcentive has managed quality for providers and healthcare stakeholders in health system, physician practice, MSSP, IDN, hospital, employer, and more recently, payer settings.

These stakeholders are pursuing an intricate array of value-based care and population health management initiatives, such as PQRS, PCMH, meaningful use, Medicaid Delivery System Reform Incentive Payment (DSRIP) and multiple private-payer quality programs.

Wellcentive maintains more than 400 reportable clinical quality measures (CQMs), ranging from National Quality Forum and HEDIS measures to more than 30 certified meaningful use measures. Wellcentive is a certified CMS Qualified Clinical Data Registry (QCDR) and is certified to ONC's 2014 Edition.

By combining clinical, pre-adjudicated and adjudicated claims data for analysis and reporting, and by capturing data across disparate systems, we are bridging the movement of quality from process to outcomes, a patient-centered movement that will aid in the advancement of a coordinated and sustainable healthcare system. Through this data governance we are aligning independent

and employed providers using multiple EHR systems toward the common goal of an enhanced patient experience, and quality and cost improvement, in line with the HHS Triple Aim.

We welcome this opportunity to offer our expertise and recommendations on CQM and certification expansion as part of the implementation considerations of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Through the Merit-based Incentive Payment System (MIPS) and the Alternative Payment Model (APM) reimbursement tracks, quality reporting and quality measures will touch all aspects of MACRA's intent, and will expand the provider types being impacted.

The stakes are high in this approaching milestone, and we believe a vision is in order that encompasses all payer types to create a process whereby increased certification and expanded quality measure sets can be welcomed as a public-private collaborative.

Frequency of Certification

Given that CQMs undergo annual updates around efficacy, accuracy and clinical relevance that impact health IT developers, Wellcentive supports the overall concept of an annual certification process in tandem.

We support offering the provider community high levels of assurance that their solution providers maintain efficient and timely versions keeping pace - and as much anticipating - public and private payer reporting needs.

An annual cadence is more relevant with the advent of MACRA, as the law intends for annual quality measure updates as a MIPS scoring pillar, and that it be done with provider input.

We could not agree more with CMS Center for Clinical Standards & Quality Director Kate Goodrich, MD, MHS, who noted in her introduction of the RFI that CMS aims to "streamline/reduce provider, hospital and health IT developer burden" through this RFI process.

To get there, Wellcentive seeks clarity on several key areas of certification:

- With the ONC 2015 Edition currently proposed to be in place for the 2017 meaningful use reporting year, is it CMS intent to expand CQM certification within a modified rulemaking process, as could be pursued within the MACRA proposed rule? Here, and elsewhere in this comment, Wellcentive recommends combining dedicated certification and CQM expansion to coincide with the 2019 launch of MACRA.
- Does CMS (in collaboration with ONC) intend to further decouple certification from meaningful use, as was begun with the 2015 Edition final rule? If so, a careful examination of a more segmented or category-dedicated certification process would be needed to assess other areas of certification, such as interoperability. (Here also we note the still-unresolved impact on CMS and ONC via current Congressional movement on health IT technology requirements that promise to play a policy role, which could also lead to certification changes in coming years or could impact the MACRA proposed rule due early this year.)
- We raise the conversation around decoupled, segmented or category-specific certifications based also on the ONC HIT Policy Committee's Advanced Health Models and Meaningful Use Workgroup meetings on the need for an APM-specific certification as part of the implementation of MACRA.

Overall, the burdens Director Goodrich intends to confront would be lessened if changes to certification and quality measures align not only with MACRA, but also with other public and private payer value-based care and incentive programs.

A New Approach Across the Spectrum

With the opportunity at hand to really impact progression on how quality measures are tested, and in particular given the current testing challenges detailed below, Wellcentive envisions a more encompassing or holistic approach that aligns private and public payer processes.

Testing and/or certifying measures at an enterprise or clearinghouse level can create an infrastructure for all payers to collaborate and participate in quality measure refinement. This structure leverages the health system, be it IPA, PHO, IDN, at a higher infrastructure or system-wide level, versus placing the burden on the individual office provider.

Historically, certification has brought standardization benefits around registry reporting and other criteria that precluded normalization across the health IT community. The establishment of privacy and security standards, though always in need of evolution, is another example.

A standardized "enterprise clearinghouse" approach to quality among broad stakeholders would lead to a more robust or richer data set, where issues can be addressed sooner and a governance approach to data quality can be introduced. This would also introduce an architecture offering traceability, scalability and data streamlining for audits, which again would embrace all payers.

This would call for collaboration with the National Committee for Quality Assurance (NCQA) and other quality-centric organizations also offering and examining certification programs, and Wellcentive commits its energies to convening public and private stakeholders to pursue this more encompassing approach.

For value-based care and population health management to continue to advance and succeed via quality reporting, a holistic approach across the payer spectrum is needed.

This approach would solidify Wellcentive's support of expanded certification and measure sets.

Changes to Minimum CQM Certification Requirements

Here too, Wellcentive supports the concept of the expansion of certified quality measures, to allow providers more vetted options to meet diverse payer programs.

It is achievable for health IT developers to certify, as Wellcentive has done, well beyond the current minimum CQM requirements for the meaningful use program, for example. The RFI's language toward moving from the current certified minimum of 9 EP and 16 EH measures to 15 and 25 respectively is a rationale beginning, provided that measures are aligned with broad stakeholder insight.

Here again special attention is expected with alignment around the quality measure MIPS scoring pillar, especially since the number of MIPS EPs will broaden beyond the provider types deemed eligible for the meaningful use program.

As noted previously, it is written into the MACRA law that providers will have input into annual quality measures submitted within MIPS, and health IT developers regularly interact with provider clients on achieving measure reporting that matches patient populations or scope of practice.

To that end, and requested within the RFI, Wellcentive recommends that urology measures be added to the PQRS specialty measure set, given the overall Medicare-relevant patient population and the specialty's role in chronic care and population health management.

We would also agree with the continuation and expansion of the current process of *recommended* core measure sets, as is done for adult and pediatric demographics within PQRS.

We emphasize the term recommended over that of certified, as overall we again believe that flexibility in provider selection of measures meeting multiple payer programs is key.

Likewise we caution against proceeding with a measure expansion certification process that would have developers or providers choosing from arguably limited "primary care," "multispecialty" or "specialty only" options as offered in the RFI. Certainly, though, in cases such as health IT solutions described as niche, as in the case of dental quality reporting modules, this type of narrow certification is relevant.

As to the process for expanding certified measures via a timeline: certifying to all CQMs in the first year of a new process; incrementally increasing certified measures until the total is met; or the option of certifying more than the current minimum but not the entire range of available CQMs, Wellcentive believes that an incremental approach is best, primarily for the reasons stated that the MACRA laws provides for annual updates, which in turn provides the opportunity for measures to be fine-tuned based on experience and broad stakeholder input, which could then be matched to incremental certification updates.

Also, given the challenges in measure testing as detailed below, we believe an incremental increase in certified quality measures beginning with the launch of MIPS, which would target a completed certification process in 2018, is a tangible goal, provided again that the expanded measures are as aligned with as many public and private payer programs as possible, to make optimal use of a new approach as we envision in Section One of our comment.

CQM Testing and Certification

By CMS' own reflection, as stated in the October, 2015 *Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models*, "CMS' experience under the PQRS has shown that data quality is related to the mechanism selected for reporting."

Wellcentive agrees with this assessment, and again sees progress with the advent of reporting vehicles like QCDR, which offer transcendence of single-program quality reporting.

For this RFI, and if an increased frequency of certification is matched with expanded sets of CQMs toward multiple and increasingly aligned quality reporting programs, then one of the greatest challenges Wellcentive sees is with the current mechanisms of testing.

Currently there are three separate testing tools that intend to validate submission files in different ways: the Cypress QRDA certification tool, optional Cypress certification/CMS IG certification and the PQRS Submission Engine Validation Tool (SEVT).

CMS has been transparent in determining the existence of errors or deficiencies in the QRDA I, QRDA III and QCDR CQM submission data, leading to your decision not to report some data types on the Physician Compare web site, not be used to determine quality performance or establish benchmarks for the 2014 reporting year.

Given this experience, and that CMS has put forth ongoing updates or revisions to the requirements for CQM submission (including changes to the Cypress certification tool, QRDA versions and to the implementation guide, which overall

occurred three times in 2015), Wellcentive strongly advises that a single validation tool for providers (and a similar single tool for hospitals) would lessen speculation and resistance to any CMS proposal to increase the frequency of certification and expanded sets of measures.

And given that testing toward certification is the pathway, Wellcentive seeks clarity on whether certification would be required to the QRDA standard *and* the CMS implementation guide. We caution against duplicative approaches, and recommend certification only to the implementation guide, from which there is assurance that CQM data would be submitted as a data type accepted by CMS.

In regard to timing, we believe annual CQM updates and/or the release of new CQMs should parallel updates to the implementation guide. The guide itself should encompass all aligned incentive and reporting programs, as well as revisions to the validation/testing tools used for electronic submission. This consolidation would lend integrity to policies.

We understand that within current policy that beginning in 2018, providers will no longer have the attestation option for the reporting of CQMs, and must instead report via certified technology.

That timeline, and given the above challenges, and in accordance with the MACRA launch of 2019, provides a targeted timeframe to streamline testing and propose the type of changes included in the RFI. Also as noted above, the advent of MACRA also lends to the launch of annual certification and measure expansion, provided again that test tool challenges can be resolved.

In Conclusion

As we all experienced with the ICD-10 conversion, the healthcare delivery and IT sectors can successfully bring about fundamental and broad advancements. (Sure, the extra year didn't hurt.)

We applaud your issuance of this RFI, because as value-based care and population health management become the keys to care delivery and reimbursement models, we are at another milestone horizon, both in terms of policy emulated by private payers and toward the crucial element of acceptance of the permanence of value-based care.

Acceptance can only come with clinical relevance, simplicity and shared goals. Wellcentive envisions a United Nations approach to quality. We have taken part in ongoing discussions with CMS, ONC, NCQA and other pertinent stakeholders, and of course with our client base and the provider community.

As with ICD-10, there is a window of time to act within, and Wellcentive stands ready to continue all discussions put forth in this comment toward a new set of best practices, in collaboration with the insights of all stakeholders.

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