Health IT Policy Committee

A Public Advisory Body on Health Information Technology to the National Coordinator for Health IT

Quality Measurement Task Force

2016 Inpatient Prospective Payment System

Cheryl Damberg, Co-Chair
Kathleen Blake, Co-Chair
June 24, 2015

Membership

Health IT Policy Committee
A Public Advisory Body on Health Information Technology to the National Coordinator for Health IT

First Name	Last name	Member Type	Organization
Cheryl	Damberg	**Co-chair**	Senior Principal Researcher, Rand Corporation
Kathleen	Blake	**Co-chair**	MD, AMA
Lori	Coyner	Member	Director of Health Analytics, Oregon Health Authority
Floyd	Eisenberg	Member	MD, MPH, iParsimony, LLC
Joe	Kimura	Member	Deputy Chief Medical Office, Atrius Health
Ginny	Meadows	Member	VP, Regulatory Strategy, McKesson Corporation
Elizabeth	Mitchell	Member	President and CEO, NHRI
Jason	Mitchell	Member	MD, Chief Medical and Clinical Transformation Officer for Presbyterian Healthcare Services
Sally	Okun	Member	VP Advocacy, Policy and Patient Safety, Patients Like Me
Frank	Opelka	Member	Medical Director of Quality and Health Policy, American College of Surgeons
Dan	Riskin	Member	MD, MBA, FACS, and CEO and Founder of Vanguard Medical Technologies
David	Lansky	Member	President and Chief Executive Officer, Pacific Business Group on Health

Quality Measurement Task Force Charge

To provide a set of recommendations regarding Clinical Quality Measurement (CQM) provisions in CMS payment rules, including the Medicare Hospital Inpatient Prospective Payment Systems (IPPS) NPRM.

QMTF recommendations are organized across 2 focus areas:

1. ONC proposal for a 2015 Edition CQM reporting certification criterion and associated standards

2. Early comment solicitation on new type of measure utilizing core clinical data elements in the Hospital Inpatient Quality Reporting (IQR) Program

Versions of standards

1. The QMTF felt that many stakeholders are still working to support QRDA reporting and that ONC and CMS should support incremental changes to the QRDA standards rather than shifting too quickly to an immature standard.
    - **Recommendation:** The QMTF supports Release 3 of the QRDA Category I standard for individual level quality reports, and the November 2012 version of the QRDA Category III standard with the September 2014 Errata for aggregate level quality reports.
        I. The QMTF supports these versions because they are incremental fixes to the versions already being used in the 2014 Edition and for Stage 2 of the EHR Incentive Programs.
        II. The QMTF also believes that developers and providers will have adequate time for implementation of these standards if they are not required for use until 2018 (the industry standard for development and implementation is 18 months from the publication of a standard and subsequent adoption by a program to its required use).

ONC Proposal for 2015 Edition CQM-Reporting certification criterion, continued

Versions of standards

2. The QMTF strongly supports the direction of the Standard and Interoperability Framework Clinical Quality Framework initiative to harmonize clinical decision support (CDS) and clinical quality measurement (CQM) standards, but the QMTF did not feel these new standards were ready or mature for adoption.
    - **Recommendation**: ONC and CMS should continue supporting development and pilots of the harmonized CDS and CQM standards – namely the Quality Improvement and Clinical Knowledge (QUICK) Fast Health interoperability Resources (FHIR)-based-standards- and drive stakeholders and vendors to move promptly in this direction when the standards become more stable and mature.
3. The QMTF recognizes that adoption of the QUICK FHIR – based standards will also require a commitment on the part of CMS to update its systems and tools.
    - **Recommendation**: The QMTF recommends CMS indicate its commitment to implementation milestones that will align with the industry and provider implementation of these harmonized standards. This alignment will allow the industry, providers and CMS to adopt the QUICK FHIR-based standards in a coordinated and timely fashion.

Measure Utilizing Core Clinical Data Elements in the Hospital Inpatient Quality Reporting (IQR) Program

1. The QMTF supports efforts to capture and use clinical enriched data from EHRs to enable risk adjustment of outcome measures, but is concerned with the issue of how best to collect this information.
   - **Recommendation:** Data elements known to be required for risk-adjusted measurement should be included in the core data set.
   - **Recommendation:** CMS should identify innovation/measurement centers that have the following capabilities and leverage them to quickly advance measurement of outcomes:
     I. Access to large sample claims and clinical data;
     II. Possess the framework for data extraction, analytics, and reporting to enable testing, measurement refinements, and collection; and
     III. Use of risk related variables for adjustment and stratification.

Measure Utilizing Core Clinical Data Elements in the Hospital Inpatient Quality Reporting (IQR) Program, continued

2. There was also concern that the data elements CMS eventually requires could grow to a large list that may be burdensome.
   - **Recommendation:** CMS and ONC should prioritize alignment of the data elements across programs.
     - For example, certain data (e.g., date of birth, age) are required to be collected in one way in the EHR Incentive Programs but are proposed to be collected differently in this CMS proposal. There should be standardization of the data elements across both programs.
   - **Recommendation:** Rather than specifying a list of data elements, the QMTF suggests better integration of the reporting requirements with existing EHR standards for reporting CQM data, such as QRDA.

3. The requirements should balance data collection necessary to measure outcomes without negatively affecting data validity and submission burden. There is a need to balance promotion of flexibility with rigorous data collection.
   - **Recommendation**: Data collection requirements should be very specified and suited for a specific application (pre-defined) rather than broad to reduce burden.

Measure Utilizing Core Clinical Data Elements in the Hospital Inpatient Quality Reporting (IQR) Program, continued

4. In relation to the comments made above about the data being pre-specified for a particular need, the QMTF felt that it was too early to definitely determine if QRDA Category I is the most appropriate standard without knowing what the required data elements will be.

- **Recommendation:** The QMTF recommends that CMS accelerate its work to identify the data elements, and the definitions of those data elements, that they intend to require so that an appropriate standard can be determined.
  - I. For example, if the data elements were defined as supplemental data to the QRDA Category I standard for a given measure, QRDA Category I may be the best option for requiring electronic submission. CDA is potentially problematic because it may contain more information than is needed to calculate the measure, and the QMTF felt that it may lead to problems including delays if CMS and health systems need to redact data prior to using it for quality purposes.
  - II. However, the QMTF did not want to definitely recommend QRDA I without knowing the entire set of data that would be required for collection.

5. **Recommendation**: The QMTF also recommends CMS use pilot projects and other approaches to test an expanded set of data elements for potential use in quality measurement by a wider set of entities (e.g. health care payers). The QMTF suggests CMS undertake such pilots after first defining the core set of clinical data elements.

Questions