

November 22, 2013

Ms. Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Room 445-G
Washington, DC 20201

Dear Ms. Tavenner:

On behalf of the Premier healthcare alliance, we appreciate the opportunity to comment on new clinical quality measures for potential use by eligible professionals (EPs) in the EHR Incentive Program. Premier is a performance improvement alliance of approximately 2,900 U.S. community hospitals and 100,000 alternate sites using the power of collaboration and technology to help lead the transformation to coordinated, high-quality, cost-effective care. Premier hospitals and health systems employ physicians and also partner with physicians across the country in seeking better ways to reduce the fragmentation of healthcare and increase coordination of care. Premier operates a number of large-scale collaboratives, including those focused on accountable care organizations (ACOs) and bundled payment, in which Premier hospital members align with physicians to push for improved quality at reduced cost. Hence, Premier has a strong interest in the measures considered for use by eligible professionals (EPs) under the EHR Incentive Program as well as those considered for use by eligible hospitals.

Background

In reviewing the two proposed measures, or any potential measure for that matter, Premier believes that the attached framework should be applied. We originally crafted this framework for adopting measures within the Hospital Inpatient Quality Reporting (IQR) program, but believe it is pertinent to physician measures and the EHR Incentive Program. Part of this process is ensuring that the fully specified measures are field tested for validity, sensitivity, reliability and other properties to ensure robust measurement (see especially items #5 and #6 in the attached framework). In this regard, we note that the Measure Justification Forms for both proposed measures indicate that a very large number of issues are “To be determined through testing” or “TBD.” While we support the intent of these measures, and are in fact working to include similar measures in our collaboratives, we are concerned that the measures have not yet been sufficiently tested or adopted by a consensus-making body. Thus, we recommend that the Centers for

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Medicare & Medicaid Services (CMS) wait to include such measures in the EHR Incentive Program until they are fully specified, field tested and endorsed by a consensus-making body.

Below, we address the three areas for which CMS specifically asked for feedback: relevance of the measures, usefulness and feasibility of data collection.

Relevance

The proposed measures are important in addressing the ongoing concerns raised by policy makers, providers and the patient population about the overutilization of certain diagnostic tests. Premier is actively working with its members to reduce patient exposure to radiation as well as reduce the provision of wasteful services. Thus, we agree that these measures are relevant.

Usefulness

The Institute of Medicine defines high-quality care as care that is effective, efficient, safe, patient-centered, timely and equitable. Subjecting patients to diagnostic testing in situations in which this testing is not known to be effective does not provide high-quality care. Patients with a very low pre-test probability of disease who undergo such testing risk unnecessary radiation exposure and being subjected to further, possibly more invasive testing for false positive results. Requiring patients to face possible economic losses due to lost productivity, time away from work, and/or copays, is not patient-centered care. Lastly, applying these tests to a population with a very low pre-test probability of disease is an inefficient use of resources and introduces waste and needless cost into the healthcare system.

Feasibility

Our greatest concerns relate to the feasibility of data collection. CMS should ensure that the measures used under the EHR Incentive Program do not require manual data abstraction (for example, to determine whether relevant exclusions apply). The essential data that is needed to capture and report these elements should come directly from the EHRs. Using EHR-based measures reduces the burden on providers while increasing their ability to use the data in real-time to improve care, as compared to claims-based or manually abstracted measures. However, we are concerned that the current state of EHR capabilities would not allow for the efficient or accurate reporting of the proposed measures. Thus far, providers have had difficulty working with vendors to introduce new EHR capabilities to support quality measures required as part of the Stage two criteria that eligible hospitals must meet in order to continue to participate in the EHR Incentive Program. We urge CMS to work with EHR vendors to ensure that future releases to their products include an ability to collect such information as part of the work flow.

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Conclusion

Premier supports the concept of the two proposed measures and agrees that they are suitable to assess appropriate utilization of imaging and diagnostic tests and have the potential for raising the quality of care delivered. However, we believe appropriate field testing is needed in order to determine whether the measures are valid, effective and practicable, and thus suitable for adoption as part of the EHR Incentive Program or any other CMS program. Moreover, CMS should assess the feasibility of collecting the measures solely through the EHR data, without any manual abstraction, before adopting these measures.

Premier appreciates the opportunity to submit these comments. Please do not hesitate to contact Lauren Choi, senior director of federal and international affairs, at 202.879.8005 or lauren_choi@premierinc.com if you would like to discuss our comments and related matters further.

Sincerely,

A handwritten signature in black ink, appearing to read "Blair Childs". The signature is fluid and cursive, with a large initial "B" and "C".

Blair Childs
Senior vice president, Public Affairs
Premier, Inc.

Attachment

Premier's recommended framework for processing, prioritizing,
and implementing quality measures

Attachment

Premier's recommended framework for processing, prioritizing, and implementing quality measures

1. CMS should undertake analyses and share them with the public, identifying areas in which it believes measures should be developed and indicate whether these measures will be reported under other existing programs, such as EHR meaningful use or separately.
2. To the extent possible, new measures should only be added to the EHR meaningful use program so that providers are not overwhelmed by competing, potentially duplicative programs.
3. The measures may be developed by various organizations across the country from academic institutions to health plans, but need to be developed with automation in mind, ideally using data elements that exist in EHRs today.
4. The measures must be considered as part of the National Quality Forum's (NQF's) consensus building process and be formally endorsed, specifying whether the measure status is field tested, and ready for provider data collection or public reporting.
5. Field testing should be conducted to validate the measures for accuracy, precision, sensitivity, specificity, efficacy, collection burden, and unintended consequences to quality of care. The unintended consequences of the measure should be evaluated with regards to patient effectiveness, patient safety, timeliness and automation.
6. If field testing identifies flaws in the measures that suggest material changes should be made, the measures should be reconsidered by NQF.
7. CMS should consult with other federal agencies such as the Centers for Disease Control and Prevention and the Agency for Healthcare Research and Quality, given their experience with developing definitions, testing, data collection, healthcare-associated infection reporting and research.
8. Through the relevant rulemaking process, CMS should include the measures that it is specifically recommending for the fiscal or calendar year following the one to which the rule applies. While CMS may discuss issues for subsequent fiscal years, it should not formally propose measures at that time.

9. In the rule, CMS should provide the public with information on:
 - The measures
 - The risk adjustment methodology
 - Who developed each measure
 - Which organization suggested the measure for CMS adoption
 - Whether the NQF is actively considering the measure or has endorsed it
 - Whether other consensus bodies are actively considering or have endorsed the measure
 - Which organizations have field tested the measure
 - The results of the field tests
 - Where related evidence-based practice guidelines can be found
 - Detailed measure specifications
 - Why CMS is adding measures outside of the EHR meaningful use program (if relevant)
 - The plan for automation of the measures
 - Where the data elements can be found in an EHR
10. CMS should consider staggering the adoption of measures to ease the burden on providers.
11. Measures should be finalized in the relevant final rule (for physicians, the Medicare physician fee schedule final rule) and not in other unrelated final rules, such as the Hospital Outpatient Prospective Payment final rule.
12. Timelines should not be presented for disease conditions or concepts of measures that are not yet in existence or sufficiently through the consensus process. Such concepts should be addressed as discussion-only items.
13. Data specifications for proposed measures should be posted at the time the relevant proposed rule is published. CMS should endorse only measures where the exact specifications and methodologies for calculation are completely public, replicable and can be automated.
14. Subsequent changes to data specifications should be posted and communicated to providers through an email list notification.
15. CMS should seek comments on the retirement of measures through the rulemaking process. Retirement should occur when the standard of care has changed or performance of the preponderance of providers is at or very near perfect. Or, when an outcome measure is integrated that can take the place of process measures (i.e., urinary

tract infection rates versus catheter removal timing). Data collection should not continue, due to burden – based on meaningful use quality measures being automated – and value-based purchasing policies, unless there is a compelling argument that the standard of care may deteriorate if collection and monitoring does not continue.

16. Once the measures have been endorsed, field tested and publicly reported for at least a year, CMS may consider integrating the measures into its public reporting and value-based purchasing policies.
17. Only metrics where the ideal performance level is known should be used in payment penalty programs. Any metric which has an unknown ideal performance level should be included in models similar to hospital value-based purchasing to avoid unintended consequences. An example of an unknown target level would be C-section rates for which there is no established ideal rate (e.g. target rate is not clearly zero nor clearly 100 percent).