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Dear Mr. Slavitt and Dr. Washington,

Please accept my thoughts on quality measurement and a direction that I think could improve the nation's chances in successful shifting to value-based payment models. I have been, at one time or another on panels with each of you and I know that we have also had a couple of opportunities to discuss these things in person. However, I have not previously taken the time to put these thoughts on paper for you, but this issue is rapidly becoming critical.

As a physician leader within the Health Information Exchange (HIE) community, I have devoted my career to leveraging Health IT to improve health and wellness, and I believe that the shift away from volume towards value is critical to aligning incentives and driving quality and efficiency in healthcare. I also believe that any payment system built on value requires credible methods and validated implementations of meaningful measures to be successful. No where, and at no time, will this be more critical than with the roll out of MACRA and MIPS as the expectations placed on providers move beyond simply *reporting* performance to actually *achieving specific performance targets* on a range of measures. The pressure on providers to perform will be enormous and I am very concerned that the healthcare industry's current infrastructure for clinical measurement is not up to the task. I am writing to support an additional pathway to measurement certification that could help to alleviate concerns.

I lead MyHealth Access Network, a 501c3 non-profit health information exchange that links more than 400 provider organizations and serves more than 3M patients in and around Oklahoma. MyHealth began as one of ONC's Beacon communities and has continued its mission to improve health in Oklahoma by serving as the Convener and Data Aggregating organization, as well as the system of record for quality measurement for the commercial payers in the CMMI Comprehensive Primary Care program in Oklahoma. As you know, the Oklahoma CPC has demonstrated significant savings and quality improvement over each of the last 3 years, and providers who performed well on quality measures were rewarded with shared savings payments—making our region one of the most successful to date in value based payment models.

Over the course of this work we have observed that the most important factor in the success of these value-based programs is the creation and maintenance of trust in the measurement process. Regardless of the payment model or system transformation proposed, if either side of the contract feels that they cannot trust the measures or the data behind the measures, the program will be short lived. Achieving trust in the quality measurement process from all stakeholders is critical.

Prior to and continuing through the CPC program, MyHealth has aggregated the clinical data from dozens of Certified EHR Technologies as well as from commercial, Medicaid, and now Medicare claims data. In addition to providing this data as a longitudinal health record for each patient at the point of care, MyHealth leverages this information to provide health analytics including the calculation of electronic clinical quality measures (eCQM's) and claims based measures. This experience has given us a unique perspective on the state of data and clinical quality measurement in the various systems that we interact with.

It is this experience that causes me to raise the following concerns about the current eCQM certification process and its results:

1. *Assurance of accuracy of the calculations as implemented across hundreds of EHR systems*: eCQM's can be very complex with many branching layers of logic that depend on accurate interpretations of data and timing of events, as well as attribution of results. Unfortunately, the current testing program only uses 56 standardized patient charts to test more than 100 complex eCQM's. In our experience this only results in 1 to 2 patients landing in the numerator or denominator for any given measures, which surely is not testing all of the potential branches in the measures' logic. Granted, the next round of EHR certification will provide more test patients for the program, but in order to be valid it seems that there should be sufficient test patient volume to test every branch of each measure's logic thoroughly.
2. *Confidence in the data provenance and quality*: Working with EHR vendors to extract data in standard formats has given us insight into the quality of data in the CEHRT's. As you know CEHRT's are required to provide exported clinical documents with data properly coded to standard terminologies. MyHealth routinely assesses the quality of the data received in the millions of clinical document files it has received and the results are often disappointing. Out of more than 700 value sets (or concepts)

required to calculate eCQM's, dozens, and often several hundred, are not supported by the data provided by most CEHRT's. This calls into question whether and how vendors are choosing the variables to be used in the measures. At some point in the process of certification, vendors must select which internal proprietary codes will qualify for standard value sets required in measures. No part of the current testing program assesses this critical step—leaving the door wide open for unexpected variability, and therefore uncertainty, to enter the measurement process.

3. *Timing and cadence of measurement certification*: As with the other modules of EHR certification program, measurement certification is only required every several years. Once certified, each vendor's implementation of measures does not undergo further scruitiny or evaluation until the next round of certification. Measures, and the science behind them, continue to advance and change. Thus, there are often new measures, and new versions of existing measures, published on an annual basis. In addition, vendor products change with upgrades, patches and other improvements on a frequent basis. Any one of these changes can alter the performance of a measure from its certified state. In order to mitigate these issues, validation of measures should become at least an annual process and perhaps should be done as often as material changes are made to the measurement product.
4. *Choosing the correct frame of reference*: Dr. Mai Pham's work published in the New England Journal of Medicine showed that the average Medicare patient sees 7 different providers each year, and his/her own PCP only a third of the time. She also showed that the average PCP must coordinate care with more than 225 providers in 117 other organizations. From my perspective, this calls into question the wisdom of measuring eCQM's at a single provider level from within a single EHR. Using the doctor as the frame of reference introduces an unpredictable variability into the measures—the same patients will appear in the measures of several and often many organizations at a rate that is difficult to anticipate. Because sicker patients tend to see more doctors, this means that the sickest patients will be over-represented in the measurement results. Thus results cannot be combined to arrive at a practice, population, payer, employer, or national result for performance on eCQM's. At best this raises concerns about the measurements and at worst undermines trust to the degree that payers and other stakeholders insist on patient-centric measurement by other methods.
   For example, some large commercial payers are ignoring the eCQM's from the practices' EHR's and instead insisting that practices send exported clinical documents from the EHR directly to them, which they then attempt to assemble into an accurate, patient-centric measurement. Others are partnering with regional data aggregators like HIE's and analytics services to extract data from EHR's and perform measurement. We also note the increased role for Qualified Clinical Data Registries in the MACRA proposed rule and other programs. This approach is similar to the regional data aggregator and has promise for addressing these concerns. All of these approaches can work to shift the frame of reference from the provider to the patient, but also have the potential to reduce variability.

Some of these issues will be partially addressed in the next round of CEHRT testing, and that is a tremendous positive. However, I recommend the selection of additional parties to certify the implementation of measures in various products and systems.

In particular, I recommend NCQA which has a long history of creating, deploying and supporting the broad dissemination and implementation of standardized measures. In addition, NCQA has taken steps in their programs to provide the assurance of validity and the process controls necessary to detect issues early and communicate clearly with interested parties when issues arise. This experience will be invaluable to the clinical quality measurement program.

In the interest of full disclosure, I am currently a voluntary, non-paid member of the NCQA board of directors on which I have chosen to serve in part because I believe in their approach to quality measurement and in particular to their ability to attain the level of rigor and standards necessary to breed trust in the results of measurement.

MyHealth is currently participating in NCQA's measure certification program and we find the approach to be highly robust for the following reasons:

a) Use of "locked-box" testing methodology, ensures integrity of test results,
b) Use of industry-standard messaging formats for interoperability testing,
c) Multiple test decks per measure with automated test results,
d) Easy to use web-based interface to conduct testing/scoring of results, and
e) Streamlined validation with team of experts for any discrepancies found.

In particular, NCQA's approach to addressing my first concern above, the validation of the calculations, involves a population of test patient CCDA's with more than 20,000 patients. Thus, each branch of each measure is tested individually with a population of patients. Concern #2 above is addressed by including incorrectly coded data in the test patients and assessing whether these issues are discovered and if cured, are cured correctly. Concern #3 is addressed by requiring an annual refresh of the measure testing but also by enabling the testing to be easily re-run whenever material changes are made to the measuring system.

Finally, the deeming of additional organizations such as NCQA to certify measures implemented by systems and organizations other than EHR vendors will create the possibility of shifting the frame of reference to the patient and having patient-centric measure results. HIE's, regional quality improvement organizations, QCDR's, and other regional data aggregation partnerships could be certified to perform accurate measurement. This will benefit CMS, as well as other payers. It could also benefit providers by offering them a more truthful view of the current status of their patients on each measure, and alleviates the pressure to repeat testing or procedures simply because the data is not stored within the provider's EHR. This of course, also benefits patients and those paying for care as well. Finally, this approach creates clear incentives for interoperability in healthcare, by enabling those who exchange data in support of patient care to perform better and use resources more efficiently.

Paying for value over volume will only be successful if measurement is valid and trusted by all parties to the contracts. For MyHealth and our region, that means that we hold our reporting systems to the higher standard of NCQA's eCQM Certification Program. We have personally evaluated the NCQA program and are seeking certification of our system. We are so confident in this methodology that we have recommended the entire 47-members of Strategic Health Information Exchange Collaborative (SHIEC)[i] to seek certification of their eCQMs using the NCQA testing platform.

It is for these reasons that we strongly encourage your approval of this testing platform and welcome further discussions on how we may be of assistance to support your approval process. Please accept these ideas in the spirit with which I offer them—I am a dedicated supporter and fan of the direction that ONC and CMS have taken to modernize the infrastructure and business practices of our nation's healthcare system and indeed hope to spend the rest of my career helping you to make it happen.

Sincerely,

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