

Implementing Qualified Clinical Data Registries Physician Views on the CMS Proposal

Earlier this year in the *American Taxpayer Relief Act (ATRA)* (Public Law 112-240), Congress created an additional pathway for physicians to participate in the Physician Quality Reporting System (PQRS) and other value-based purchasing programs. Section 601(b) of ATRA recognizes the tremendous opportunity to leverage clinical data registries to measure and improve health care through a process whereby physicians participating in a qualified clinical data registry are "deemed" to have satisfied quality reporting requirements under PQRS and other Medicare quality improvement programs. Clinical data registries represent the future of quality measurement and performance improvement. If implemented successfully, the provisions of Section 601(b) have the potential to encourage broad physician participation in meaningful quality improvement activities.

Unfortunately, the physician community has a number of concerns with the structure of the new Qualified Clinical Data Registry (QCDR) program, as initially proposed by the Centers for Medicare & Medicaid Services (CMS). We believe ~~some~~ modifications are needed to fully leverage the important role that clinical data registries will play in quality improvement in the coming years.

Concerns

- ❖ CMS must understand that medicine, as a whole, is in the relatively early stages of instituting widespread quality programs and it is important to recognize that clinical data collection efforts vary greatly among the specialties.
- ❖ CMS has placed unnecessary restrictions on the innovation that the statute intended to foster by proposing that physicians who report to QCDRs must:
 - Meet the minimum number of measures required for participation in conventional PQRS reporting — an increase of 3 to 9 measures, across 3 of the 6 National Quality Strategy domains;
 - Report on 50 percent of all applicable patients, as is the case with the conventional PQRS threshold requirement; and
 - Comply with a qualification process for new and established clinical data registries that may unnecessarily eliminate suitable QCDRs.
- ❖ While transparency and public reporting are important goals, it is premature for CMS to require public reporting of QCDR data at the individual provider level. Registry reporting improves care and standardizes performance without the need to publicly report individual level data. If data is publically reported at the onset, physicians — particularly the outliers — will be hesitant to participate in this more innovative quality improvement program.
- ❖ A robust auditing system is essential for CMS and the public to have confidence in the data submitted to QCDRs. However, per the proposal, if a registry submits inaccurate data, the registry is automatically disqualified from PQRS participation in the following year, and the data submitted for eligible providers is excluded.

Recommendations

- ❖ CMS should emphasize quality over quantity of measures, and QCDRs should have the flexibility to define the number of measures that a physician must report to satisfy registry reporting requirements. Key outcome and other measurement approaches that are applicable to individual specialties can demonstrate physician quality performance, without the need for artificial minimum requirements.
- ❖ CMS should allow QCDRs the flexibility to choose an evidence-based sampling method (e.g., 20 consecutive patients, random samples, etc.), rather than requiring rigid thresholds (i.e. 50 percent of all eligible patients).
- ❖ To streamline the review process and facilitate participation in the QCDR program, the participation threshold (currently set at 100) look-back should be Jan. 2014 rather than 2013.
- ❖ CMS should adopt a graduated approach to public reporting in the new QCDR program and public disclosure should be voluntary until the agency and physician community have more experience with QCDRs.
- ❖ The statute does not grant CMS the authority to collect raw data from clinical registries; thus CMS should only collect aggregate numerator and denominator data or information on whether or not a physician is satisfactorily reporting to an approved QCDR.
- ❖ CMS should not require reporting patient-level data unless it is somehow integral to the calculation of the measure. The volume of data necessary to produce patient-level reports for CMS would be extremely burdensome for QCDRs. Additionally, CMS should not have access to patient-level data for patients that are not Medicare beneficiaries.
- ❖ Physician group, rather than individual, is the most appropriate measurement level for reporting.
- ❖ Instead of automatic disqualification and exclusion of reporting data, CMS should institute an appeals process so registries and eligible professionals can determine the causes for the submission of inaccurate data and allow corrections to be made. In most situations, the inaccurate submission will not be fraudulent in nature, but rather caused by issues that can easily be rectified.

Physician Registry Coalition

American Academy of Ophthalmology
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American College of Cardiology
American College of Emergency Physicians
American College of Gastroenterology
American College of Surgeons
American Gastroenterological Association
American Joint Replacement Registry
American Society for Radiation Oncology
American Society of Anesthesiology
American Society of Clinical Oncology
American Society of Nuclear Cardiology
American Society of Plastic Surgeons
American Urological Association
California Joint Replacement Registry
North American Spine Society
Society for Vascular Surgery
Society of Interventional Radiology
Society of Thoracic Surgeons

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