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Via Electronic Submission (MACRA-MDP@hsag.com)

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Andrew M. Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
MACRA-MDP@hsag.com

Re: AAMC Comments on CMS Quality Measure Development Plan

Dear Acting Administrator Slavitt:

The Association of American Medical Colleges (AAMC or Association) welcomes the opportunity to comment on the draft CMS Quality Measure Development Plan for supporting the transition to the new Medicare Merit-based Incentive Payment System (MIPS) and alternative payment models. The AAMC is a not for-profit association representing all 145 accredited U.S. allopathic medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 148,000 faculty members, 83,000 medical students, and 115,000 resident physicians.

The AAMC appreciates CMS' publication of a strategic framework for the future of clinician quality measure development to support MIPS and APMs. AAMC is committed to partnering with CMS and other stakeholders in the establishment of a set of meaningful measures.

Overarching Comments

We applaud CMS for recognizing the importance of having meaningful measures available to physicians to report in MIPS and APMs. Certain types of measures might be more appropriate for certain physicians than others, and some specialties have very few measures available to report. Therefore, we are pleased to see that CMS is continuing to address measurement gaps and to improve the existing set of measures. Key issues CMS should consider regarding quality measurement under MIPS and APMs include the following:

- **Appropriate Risk Adjustment:** Outcome measures must be risk adjusted before inclusion in Medicare quality programs. Differences such as patient severity, rates of patient compliance with treatment, socio-demographic status, patient engagement, patient

preferences for treatment approaches, and sites of care, can all drive differences in outcomes. The issue of addressing sociodemographic factors is critical, particularly when measuring outcomes among certain populations. Appropriate risk adjustment is essential so that differences in patient characteristics that are beyond a health care provider's control do not have an unfair impact on a provider's performance score either under MIPS or any other program. The AAMC requests that CMS support additional research efforts to examine and account for appropriate risk adjustment moving forward.

- **Holistic and Continuous Review of Measures**: CMS should review measures in the Medicare programs holistically in order to ensure that new measures add value, are useful for consumers, and promote alignment across programs. The Agency should develop a process to routinely identify and remove those quality measures that are either topped-out or no longer adhere to clinical guidelines.

- **Follow a Transparent Process**: Measures should be developed through a transparent process that engages stakeholders in the development. There should be a process in place for removal of measures that are "topped out", no longer comply with clinical guidelines, or are duplicative.

- **Sufficient Time for Implementation:** CMS should ensure that physicians have time to adapt to new measures. As additional measures are incorporated into the MIPS performance programs, CMS should ensure that individuals and group practices have sufficient time -- a minimum of 18 months -- to implement the necessary infrastructure to capture and test such information before a measure is required under the performance categories.

- **Reduce Administrative Burden**: As physicians transition to the MIPS program and alternative payment models, CMS should take steps to limit administrative burden associated with reporting quality measures under these programs. Reducing burden in measurement reporting and documentation requirements will enable physicians to focus on high quality patient care.

Multi-Payer Applicability Measures (page 23)

MACRA requires CMS to consider how measures used by private payers and integrated delivery systems should be incorporated in Medicare quality programs. Quality measures currently in use by public and private payers include multiple measures for the same measure topic, resulting in duplication. CMS plans to leverage multi-stakeholder groups, such as Measures Application Partnership (MAP), the Core Quality Measures Collaborative, and the Health Care Payment Learning and Action Network (HCPLAN) to identify creative solutions.

The AAMC supports the continued use of the MAP to advise on prioritization of measures for the MIPS program and to help identify critical gaps in measures. MAP obtains input from the public as part of the MAP review process, which helps to identify the most appropriate measures. However, we recommend that CMS and MAP establish a longer time frame for public review and comment on measures under consideration. We also support CMS continued participation in the Core Quality Measures Collaborative and the Health Care Payment Learning and Action

Network. We recommend that CMS share and ensure consistency in the strategies of these groups related to the quality measures, attribution, risk-adjustment methodology, and other recommendations.

Quality Domains and Priorities (page 30)

MACRA identifies five quality domains (i.e., clinical care, safety, care coordination, patient and caregiver experience, population health and prevention) for measures developed under the MDP. CMS states that it will collaborate with specialty groups and associations to develop measures that are important to patients and providers and that represent important performance gaps. CMS indicates that it will prioritize outcomes, person and caregiver experience, communication and care coordination and appropriate use/resource use.

As recommended by the IOM in its April 2015 Vital Signs report, the AAMC supports the inclusion of core measure sets to help reduce provider reporting burden. Core measures are high impact metrics that would be required to be reported by all physicians. Core measures sets are intended to help level the playing field by discouraging physicians from exclusively reporting low-value measures. That being said, the AAMC does not believe that the National Quality Strategy (NQS) domains are the right approach for developing a core measure set. Too often, the NQS domains lack a sufficient number of relevant measures for physicians, making achievement of these domains impossible. The AAMC asks CMS to engage stakeholders to determine appropriate core measure sets for the MIPS program.

CMS should focus on a limited number of process and outcomes measures that are broad enough to ensure participation among a range of specialties. To accomplish this goal, the Association recommends that CMS work with stakeholders to perform a holistic review of the current measures in the PQRS, VM, and Meaningful Use (MU) programs. The Agency should select those measures for the MIPS that are high-impact due to either significant variation in performance among physicians or because the measures fill a recognized quality gap.

Clinical Care (page 31)

The clinical care domain consists of measures that reflect clinical care processes closely linked to outcomes or measures of patient centered outcomes. CMS states in the plan that outcome measures and adherence to clinical practice guidelines are measurement development priorities for MIPS and APMs.

AAMC supports the development of valid and reliable outcome measures that could potentially lead to more direct measures of quality and encourages their development. We recommend that CMS acknowledge that outcome measures at the physician level can be particularly challenging when used in quality programs due to small sample sizes, risk adjustment, attribution, and the impact of factors outside of the physician's control.

The issue of addressing sociodemographic factors, particularly when measuring outcomes is critical. Recent studies have clearly demonstrated that SDS variables (such as income and education) are risk factors for adverse outcomes. Physician practices that care for vulnerable

patient populations are disproportionately disadvantaged when SDS factors are not accounted for in outcome measurement. Many of the patients cared for by AMCs are poorer, sicker and more complex and therefore typically require higher resource utilization. In order to reasonably compare physicians who treat a range of patients with different case mixes, outcome measures must be adjusted for both clinical and SDS factors, and should incorporate beneficiary risk score. The AAMC believes that there are ways to appropriately adjust for SDS by incorporating SDS factors in the risk adjustment methodology. The AAMC also believes that outcome measures should be adjusted for patients who do not comply with clinician guidance.

Care Coordination (page 32)

In the draft MDP CMS discusses the inclusion of care coordination in the MIPS performance category of clinical practice improvement activities. To promote improved care collaboration, CMS highlights the need for primary and specialty accountability across care settings. Care for patients, particularly those with multiple chronic illnesses, is done by providers across many specialties. The AAMC strongly supports a system that avoids redundant care, conflicting management advice, high costs and inconvenience.

An example of a model that promotes care coordination can be found in the AAMC's work with 5 academic medical centers. Working under a CMMI Health Care Innovation Award's grant, the AMC's are implementing a new model of care delivery and technology to allow primary care providers to receive timely, electronic consultations from specialist colleagues. The primary care physician and the specialist receive reimbursement for the time they spend on the consult provided that the consult does not become a referral for a specialty visit. These e-consults enhance care coordination between providers, thereby creating sustainable reductions in unnecessary care. When appropriately implemented, we believe this will reduce costs, utilization, increase patient satisfaction, and improve quality.

AAMC recommends that CMS recognize in the draft plan the importance of developing measures of team-based care. Given the complexity of patient care, it is common for multiple clinicians to provide care to the same patient as part of a team with the goal of the best possible care. Each clinician relies upon information and action from other members of the team. A high performing team is an essential tool for a patient centered, coordinated and effective health care delivery system. In the future, it will be important to measure how a team performs on health care quality, costs, and health outcomes.

Population Health and Prevention (page 34)

MIPS allows for the use of "global and population based measures" in the quality performance category. CMS states in the report that it will consider developing or adapting outcome measures at a population level to assess the effectiveness of health promotion and preventive services. CMS references the Measure for Adult Smoking Prevalence (NQF #2020).

AAMC has concerns with applying measures that were designed for use at the "population" level to clinicians. Population based measures are typically designed to allow communities to evaluate their systems at a macro level and so have not been tested for use at the clinician level. For

example, CMS is currently using two population based measures, PQI 91 and 92, in the physician value based modifier program. These measures were originally designed to measure ambulatory sensitive conditions based on a large sample size (100,000) at the community level. Applying these specific measures that are intended to address overall admission rates at a population level to individual physicians in the Value-based modifier program has penalized physicians who treat patients with multiple chronic conditions. The bias against providers who care for complex patients is clearly demonstrated in the 2015 Value Modifier Experience Report. This report showed that of the 106 groups that went through quality tiering, none of the groups with the patients in the highest quartile of risk received an upward adjustment, and a little over 30 percent had a downward adjustment. Therefore, we have significant concerns with the use of PQI 91 and 92 and other similar population based measures in the MIPS program. The MAP Clinician Workgroup reviewed PQI 91 and 92 at its meeting in November 2015 and expressed similar concerns with the application of these population based measures to individual clinicians. Therefore, the AAMC requests that PQI 91 and 92 be removed from all physician performance programs, and that CMS avoid the future inclusion of population based metrics in the MIPS program and APMs until these issues have been resolved.

Efficiency and Cost Reduction Measures (page 34)

In addition, to the five quality domains identified in MACRA, CMS proposes to include efficiency and cost reduction as a quality domain. This domain consists of quality measures that reflect efforts to lower costs, reduce errors, and significantly improve outcomes. CMS indicates in the plan that measures of appropriate use of services, including measures of overuse, are a very high priority for measure development for MIPS and APMS. CMS indicates that it will ensure that measure developers consider evidence-based practices related to overuse and references the Choosing Wisely Initiative.

The AAMC supports the use by physicians of evidence-based clinical support systems to guide their treatment for particular patients. The Choosing Wisely Campaign's purpose is to promote conversations between patients and their providers around potentially unnecessary tests, treatments, and procedures. The Choosing Wisely guidelines are not intended to be absolute. We recommend that any measures of overuse based on "Choosing Wisely" guidelines be implemented after the specialty that provides the service have chosen to use the guidelines to create applicable measures that are based on solid evidence, and developed through a process that is inclusive of all specialties that provide the service in question. In the interim, physicians who follow the Choosing Wisely guidelines should be given credit in MIPS under the Clinical Practice Improvement Category**.**

As providers focus on performance on overuse measures, a potential unintended consequence of quality measurement is underuse of services. As measures are developed for other quality domains, CMS should also consider the development of "balancing measures" that can mitigate the potential for unintended consequences.

Furthermore, CMS should be careful to avoid quality measures that would hinder the use of more costly procedures without considering the beneficial outcomes of these procedures. Some

procedures may have higher upfront costs, but have better outcomes and result in lower costs in the long-term.

Quality Measures Use In APMs

The AAMC recommends that in the Draft plan CMS address the approach to quality measures that would be used for eligible alternative payment models. MACRA requires the MDP requires quality measures used in APMs to be comparable to the quality measures used in MIPS. The AAMC urges CMS to allow for maximum flexibility in how quality is measured for APMs. "Comparable" does not mean "the same" and should not be defined that way. APMs are newer and more innovative models of care. It is important that APM quality measures are consistent with this new way of delivering care. Quality in an APM may involve reductions in cost, increases in efficiency, and improved outcomes. Additionally, measures used to assess quality in an APM should ideally be reviewed by stakeholders, tested, and continuously evaluated to ensure that the quality metrics are meaningful to both the patients and providers. Finally, as noted by the AMA, quality measure reporting for an APM should be no more burdensome than under MIPS. There should be a focus on harmonizing measures so that there is consistency in how care is measured among MIPS and, APMs, and Medicare and other payers.

CMS Should Ensure that Publicly Reported Data is Valid, Reliable, Accurate, and Meaningful

In the Draft plan, CMS discusses the MACRA requirement that performance and participation information under MIPS and APMs be made available for pubic reporting on the Physician Compare website. CMS intends to continue public reporting of performance results through the Physician Compare website based on measures in the MIPS program through either the clinician web page or through a downloadable spreadsheet. We recommend that CMS include a more robust discussion in the draft document regarding plans for public reporting of physician performance on quality measures under MIPS.

The AAMC recommends that in the initial years of the MIPS program, CMS include data indicating whether an eligible professional (EP) satisfied the reporting requirements for the quality measure. However, calculating and displaying performance data on the public website in the early years of the program would be premature. At this early stage there are too many challenges with measures related to risk adjustment, attribution, sociodemogaphic factors to publicly report performance data CMS should only report measures that are valid, reliable, and accurate, and are meaningful to consumers and providers. Physicians should have the opportunity to review data for accuracy and request that errors be corrected prior to public reporting.

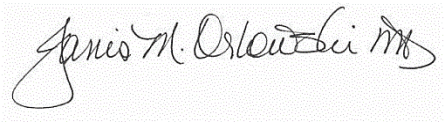
Consideration for Electronic Specifications (page 38)

In the draft plan, CMS discusses the challenges facing electronic clinical quality measure (eCQM) selection for MIPS and APMS. The AAMC requests that's the quality development place reflect the considerable burden that new eCQMs place on providers. Physician practice EHRs need to be frequently reconfigured to meet the needs of the MIPS and APM reporting

requirements. Therefore, the Association asks that the draft plan reflect concerns that new eCQMS should not be added or removed more than once per year, and should give providers multiple years of notice regarding changes to the e-CQM requirements. Physicians need substantial time to understand and implement new e-CQMS before they are publicly reported. The AAMC asks that CMS work with other governmental agencies to standardize protocols across electronic medical systems in order to help reduce provider burden.

Thank you for consideration of these comments. The AAMC looks forward to continuing to collaborate with CMS in the future as you work to identify measurement and performance gaps, and develop quality measures for use in MIPS and APMs. If you need additional information, please contact Gayle Lee (galee@aamc.org, 202-741-6429) or Scott Wetzel (swetzel@aamc.org, 202-828-0495).

Sincerely,



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