AMA AMERICAN MEDICAL ASSOCIATION

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The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Verma:

The American Medical Association (AMA) is writing in regard to funding for the development of quality measures under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Specifically, the AMA has concerns with the delay of the release of funds awarding contracts for funding opportunity per *CMS-1V1-18-002: Measure Development for the Quality Payment Program*. As we have highlighted previously, timely and targeted funding for measure development is critical to the success of Medicare physician payment reform. Thus, we urge the Centers for Medicare & Medicaid Services (CMS) to prioritize measure development efforts generated by or in concert with the medical profession.

We have continually called for federal funding to support physician-led quality measure development, which will allow CMS to support the development of meaningful measures to be used by physicians who participate in new payment and delivery models designed to improve the quality and efficiency of care. MACRA specifically authorizes $15 million per year for each of fiscal years 2015 through 2019, for a total of $75 million, to fund the development of physician quality measures for use in the Merit-based Incentive Payment System (MIPS). The statute states that "the Secretary shall enter into contracts or other arrangements with entities for the purpose of developing, improving, updating, or expanding in accordance with the plan under paragraph (1) quality measures for application under the applicable provisions." The statute also states that "such entities shall include organizations with quality measure development expertise." We believe the statute intended "organizations with quality measure development expertise" to be physician-led organizations that have devoted substantial time and resources to developing and refining quality improvement and/or measure development activities. These include the PCPI Foundation® (PCPI®) and the medical specialty societies. We also believe that preference should be given to organizations that develop quality measures through a transparent process, which may include soliciting feedback from various stakeholders during measure development; sharing measure information with CMS as part of the qualified clinical data registry (QCDR) reporting process; and publicly posting measure descriptions and information on the measures. We believe that approaches such as these will earn the trust of both physicians and patients.

It is also important that measure development initiatives adhere to certain processes to ensure that the measures are meaningful to users, uphold national standards, and harmonize with existing measures in widespread use. Measure developers should have expertise with clinical quality measure standards currently in use (e.g., Clinical Quality Language, HL7 HQMF eMeasure) and be involved in national

efforts focused on the future direction of health care standards. By working with physician-led organizations to develop the measures, this will also enhance physicians' engagement and trust in the process and assist with the successful implementation of the MIPS program. Furthermore, it will ensure that new measures are harmonized with specialty societies' alternative payment models and QCDR activities.

In addition, we would disagree with any funding proposals that rely on administrative claims measures and the application at the individual physician or practice level of claims-based population-level measures, such as the All-Cause Readmission measure. Measuring quality based on administrative claims data does not provide physicians with real time information about their patients, which they need to establish care coordination and disease management interventions. Clinical data is a richer data source because it incorporates information that cannot be documented on a claim such as family history, patient allergies, functional status, and patient-generated health data. Clinical data is also needed to appropriately risk-adjust for differences in the stages of disease, social risks and other factors. In addition, claims data does not allow physicians to utilize predictive analytics to optimize their performance, know how they are performing compared to their peers, or implement improvement strategies. In the era of electronic health records, registries and innovative digital health tools, relying on administrative claims data to assess performance is a step backward and discourages physicians and the greater health care system from adopting electronic tools to improve care.

The Department of Health and Human Services is currently under contract with an outside entity that is widely recognized for its role in endorsing measures and identifying priorities for measure development and measures gaps pursuant to section 1890 of the Social Security Act (42 U.S.C. 1395aaa). However, to maintain the integrity of the MIPS program and avoid potential perceived perceptions of a conflict of interest, any entities receiving funding for quality measure development should not also be involved in endorsing quality measures. Measure evaluation and endorsement should remain impartial, and be kept completely separate from measure development. We believe firewalls such as the ones suggested here are necessary to ensure the integrity of the measure endorsement process. We also believe it would be detrimental for a single entity to be responsible to implement all domains of the quality agenda, from measure development to measure endorsement. In addition, it might limit access to a wide range of ideas, clinical and practical perspectives, and discourage innovation, which is truly needed for there to be a successful quality improvement program.

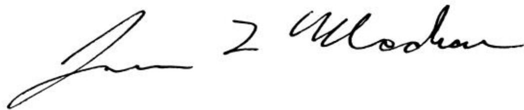
The AMA is concerned with the repeated delay of the release of the measure development funding. The original forecast announcement was released by CMS on May 10, 2017. With letters of intent due September 2017, however, the announcement was pulled and delayed several more times with the latest closing date of May 30, 2018. CMS has yet to clarify why there has been such a severe delay and the availability of an adequate portfolio of appropriate quality measures is key to achieving the legislation's goals.

We understand that CMS is confronting a number of MACRA-related mandates with very tight turn-around times. However, the majority of these other mandates rely in one way or another on quality measurement. Therefore, we are troubled by the U.S. Department of Health & Human Services' lack of expediency in addressing this critical need, especially since adjustments under MACRA's MIPS begin in 2019, based on 2017 reporting. In addition, the CMS deadline for measures to be considered for the 2019 reporting period closed in June of 2017 and the 2020 reporting period measure submission deadline closes in June 2018. Therefore, the earliest we envision any measures making it into the MIPS program funded

through the Quality Payment Program measure development cooperative agreements would be program year 2021.

The success of MACRA and MIPS is contingent upon all physician specialties having a sufficient set of actionable and relevant measures that improve patient care and allow physicians to comply with the program. We believe that Congress intended to encourage these activities and CMS should move promptly to release funds for this purpose and ensure they go to physician-led quality measure developers. If you have any questions regarding this letter, please contact Koryn Rubin, Assistant Director, Federal Affairs, at koryn.rubin@ama-assn.org or 202-789-7408.

Sincerely,



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