September 10, 2012

Re: *Measure Applications Partnership Strategic Plan and Families of Measures Reports*

The American Medical Association (AMA) is pleased to have the opportunity to comment on the draft Measure Applications Partnership (MAP) Strategic Plan and Families of Measures Reports. We commend the MAP staff and its various Taskforces for their work to better define the activities of the MAP, as well as its processes for how to provide useful upstream recommendations on measures use across public and private programs.

The AMA has long been and continues to be committed to the development of quality improvement initiatives that enhance the quality of care provided to patients. It is from this perspective that we offer the following comments.

MAP STRATEGIC PLAN

Feedback Loops

The Strategic Plan discusses the need for multi-directional collaboration among the many stakeholders engaged in performance measurement efforts to achieve the goals of the National Quality Strategy (NQS). The AMA agrees that feedback loops are essential for creating timely and meaningful collaboration around performance measurement. To maximize efficiency of resources, we recommend that the MAP balance the need to establish an infrastructure for feedback loops with existing feedback activities already in place. These current feedback loops include among others, monthly Centers for Medicare and Medicaid Services (CMS) national provider calls, where callers provide direct feedback to the agency about what measures are not being captured correctly, to issues around claims processing with data warehouses; CMS calls with measure developers to review measure specifications and testing results; specialty society input through the AMA convened Physician Consortium for Performance Improvement (PCPI) during the measure development and testing phases; and monthly calls the hospitals convene with CMS staff involved in Hospital Compare, hospital value based purchasing, and the Hospital Inpatient Quality Reporting program. While these current feedback loops are not interconnected, it is important to recognize that they exist, and provide opportunities to foster and collect useful feedback on the development, maintenance, testing, and use of measures across a variety of CMS programs. **The AMA encourages the MAP to use existing feedback loops so that additional infrastructure will only need to be created to gather information that is not currently available.**

It is important to note that the work of the National Quality Forum (NQF) to endorse measures for use serves as another important feedback loop. **The AMA urges the MAP to define how it will monitor and track the NQF consensus development process (CDP) to appropriately develop and update its Families of Measures.**

Approach to Stakeholder Engagement

The AMA welcomes the opportunity to speak with the MAP to identify opportunities to partner on engaging the physician community around the work of identifying quality measures for use, providing feedback on their use, and filling measurement gaps. Specifically, the PCPI has a wealth of knowledge and experience working with the medical specialty societies to develop, test and maintain clinically relevant measures, and identify data sources necessary to facilitate timely and accurate quality measure capture. In addition, the PCPI has supported the concept of "groups of measures" since its inception by indentifying and developing measures sets. Most recently, the PCPI has created dashboards of measures which link desired outcomes to measures (see attached example). We would welcome the opportunity to share what we have learned with the MAP as it develops its Families of Measures.

Addressing Measure Gaps

It is important not to duplicate efforts to fill measurement gaps. The PCPI, medical specialty societies, and other measure developers like The Joint Commission (TJC) and National Committee for Quality Assurance (NCQA) are continuously updating their measure development work plans. The duties and responsibilities outlined in Sec. 3014 of the Affordable Care Act (ACA) provide a clear guidepost for MAP as it continues its work on recommending quality measures for use. **The AMA urges the MAP to focus its work on highlighting the areas where there are measure gaps, and then communicating these gaps clearly to measure developers, and large organizations like the AMA and others who are able to communicate these gap areas to others.**

One significant barrier to filling measure gaps is resources—without resources it will be very difficult to be responsive to those who are in need of these measures eg, CMS, private plans, health system, consumers. While the MAP was funded under Sec. 3014 of the ACA to carry out its consensus development work for recommending measures, and the NQF was funded under the Medicare Improvement for Patients and Providers Act of 2008 to endorse measures, the other leg of the measurement enterprise stool—measures development—was not. The AMA is working with The Stand For Quality Coalition to promote legislation that would secure funding, which if enacted, would help to support the development, specification and testing of quality measures in gap areas, as well as annual updates and maintenance of measures currently in use in various programs.

Defining Measures Implementation Phasing Strategies

In general, the AMA supports the proposed added categories in the Strategic Plan of "Support Direction;" "Phased Removal;" "Do Not Support;" and "Insufficient Information." **These additional categorizations will allow the public to quickly identify where the measure concept stands in the MAP review process, which will improve how the MAP's measure categorizations are publicly perceived and acted upon.** This is a much more constructive approach than the MAP's "do not support" category for measures that did not have specifications, but were good concepts, which

sent the wrong message to payers, measure developers, and physicians. Several specialties that proposed various measure concepts to CMS expressed concern that use of the term "do not support" would signal to the public that it is not a good concept, and therefore a non starter for development work. Therefore, it is important that the MAP's recommendations are not misconstrued when electing the "do not support" category.

We urge caution, however, around the use of the MAP category "phased removal." There is a growing tension between having clinically relevant measures to promote meaningful participation in Medicare quality reporting programs, like the Physician Quality Reporting System (PQRS), and the push for high bar, publicly reportable, aligned measures across settings. However, with CMS determining in its 2012 Physician Fee Schedule Final Rule that 2015 PQRS penalties will be based on 2013 performance, the stakes for meaningful participation in this program, as well as other CMS programs, have increased. If existing quality measures currently in use within federal programs like the PQRS are recommended for phased removal, what would this mean for CMS and physicians who are reporting these measures under the program? Would MAP guarantee that other comparable quality measures would be available to replace the existing relevant measure? If so, who will pay to have these measures developed, specified and tested? What if the measure recommended for "phased removal" is the only clinically relevant measure available for a particular specialty society? Will MAP acknowledge this in its "phased removal" decision? **The AMA urges the MAP to further consider in its measure recommendations the issue of promoting the availability of clinically relevant measures for all physician specialties when deciding upon measure categorizations.**

In addition, for those measure recommendations that fall in the categories of "support direction" or "insufficient information," it would be helpful if the MAP provided input to measure developers which of these measures should be prioritized for additional development, specifications and testing. With limited resources, it is critical that measure developers receive strong green light, yellow light, or red light signals with regard to what measures are needed in the near and distant future.

FAMILIES OF MEASURES

Approach to Identifying Families of Measures

MAP seeks to align performance measurement across Department of Health and Human Services' (HHS) programs and between the public and private sectors, while identifying the best available measures to use for specific purposes. As a primary tactic to accomplish these objectives, MAP will identify Families of Measures to promote measure alignment and will create measure sets to encourage best use of available measures.

While the AMA supports efforts to better align measurement to link measures to outcomes and to create a comprehensive view of care to support improvement, payment, and public reporting, it is critical that the goal of alignment does not usurp the need to

carefully and methodically recommend (or in some cases not recommend) measures for certain quality payment and improvement programs. **MAP must balance the trade-offs between the desire to have broad measure accountability with the need for precise measurement and reporting.**

It should not be assumed that measures designed and validated for use only at the health plan level are appropriate for use at the individual physician or small group level. For example, NCQA's relative resource use measures are intended for use at the health plan or large physician group level where a sufficient sample size can be reported and are expected to produce reliable and valid results. It should not be assumed that these measures can be used to assess individual clinicians. Indeed, these measures are not proposed for use by NCQA or endorsed by NQF for use beyond assessment of health plans or large group practices. There are numerous reasons why measurement varies across health care settings. These include, but are not limited to: methodological problems with attribution and/or risk adjustment at various levels of attribution; measures have not completed testing and therefore have not been able to receive full NQF endorsement; funding is not available to help evolve a measure concept by adding specifications; or there is no solid evidence base available that justifies the development and use of a measure within a particular health care setting. **To better explore measure application across settings, the AMA recommends MAP consult with measure developers for the particular measures MAP is considering for use in alternative settings or levels of evaluation.**

We also request that the issue of attribution be highlighted in the Families of Measures' reports. We are concerned that without explicitly addressing the issue of attribution within the Families of Measures, CMS and private payers could inappropriately act upon MAP's measure recommendations. Since not all physicians currently practice within integrated delivery systems or accountable care organizations, there remains a need for measures at other levels of attribution, such as the individual physician or small group level. If a more granular level of measurement is desired, we recommend MAP consider selecting measures developed by PCPI, which are typically developed for application at the individual, small and large physician group level, and as well as the organization level. Additionally, PCPI measures include exceptions to account for patient preference in their care. If measure gaps remain, then MAP should take action to follow-up with current measure developers to better understand why current measures are only specified and captured at a specific level of attribution.

According to the Section 3014 of the ACA , MAP has appropriately not been charged with modifying measures outside the widely accepted NQF CDP. We are therefore concerned by the Families of Measures' reports that propose modifying measures for use outside of the use for which they have been endorsed. Specifically, the reports are recommending that some measures that are currently specified for the inpatient setting, be specified for use in the physician office setting. Such recommendations raise many questions around whether the evidence base supports changing the applicability of a measure from one setting to another. Furthermore, when a measure is endorsed by NQF, it is based on testing within a specific setting, *e.g.*, physician office, inpatient.

Recommending the measure be applied in a different setting would require the measure to reenter the NQF endorsement process, and the measure developer to conduct additional review of evidence base, development of new specifications, and additional testing. **The MAP should further define how the current NQF endorsement criteria (and pending redesign) will interact with measures recommended by the MAP for use in different settings and at different levels of attribution.**

We appreciate your consideration of our comments and look forward to working with MAP and other stakeholders on promoting the use of clinically relevant and meaningful quality measures across public and private programs.