American Medical Group Association®

March 1, 2016

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Mr. Slavitt:

On behalf of the American Medical Group Association (AMGA) thank you for the opportunity to comment on the Center for Medicare and Medicaid Services' (CMS) "Quality Measurement Development Plan: Supporting the Transition to the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs)" (MDP).

Founded in 1950, AMGA represents more than 450 multi-specialty medical groups and integrated delivery systems representing about 177,000 physicians who care for approximately one out of every three Americans. Our member medical groups are working diligently to provide innovative, patient-centered medical care, support transparency of health care data, and improve care while driving down overall healthcare spending.

AMGA's comments address the five "quality domains" that Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) identifies.

Quality Measure Choice

The MDP notes on page 12 that under the Physician Quality Reporting System (PQRS), providers "had the opportunity to earn an incentive payment by satisfactorily reporting data on measures chosen from a designated set." We believe that under MACRA, providers or eligible professionals (EPs) should be able to retain their ability to choose appropriate measures within a "designated set." Despite the strong desire to create a universal quality measure set, or to harmonize measure sets, the fact remains no measure set equally applies across all provider practice settings. The Core Quality Measures Collaborative started with seven measure sets that recognize seven prevalent specialty practices. We also believe providers should be given the opportunity, within limits, to develop evidence based measures, as has occurred in California. Providers would then have the option to report these measures, which would be independently audited, via national reporting mechanisms. This option offers several benefits. For example, this would allow for greater provider engagement and ownership, allow for timelier provider performance feedback, and allow for or incent more timely quality measurement development.

Quality Measurement Reporting

The MDP notes on pages 9 and 21 that CMS intends to hold both "individual clinicians and group practices" accountable for quality performance. AMGA supports this idea in concept but recommends

the MDP final draft specifically define when quality will be measured at the individual or EP level and when performance will be measured at the group level. Among other reasons, per CMS' own Medicare chart book, two out of three Medicare beneficiaries suffer from two or more chronic conditions. Measuring care outcomes for these beneficiaries at the EP level, or at the EP level only, is inappropriate. This would discourage team based care or undermine optimal clinical performance under the "care coordination" quality domain. We agree that certain services and procedures need to be measured at the EP level. Others, however, are more appropriately measured at the group level or by tiers. The MDP should define when CMS will measure quality performance at the EP and/or group level under MACRA.

Quality Attainment Versus Improvement

In context of the MDP's discussion of the "applicability of measures across healthcare settings" on page 36 and elsewhere, quality measures should not be applied equally across healthcare settings. Not all patients or all patient panels are alike or comparable. They vary considerably by demographic, environmental, genetic, and socio-economic factors. The MDP acknowledges this in its discussion on page 20 where CMS states that it will adopt "statistical risk adjustment models that account for differences in patient demographic and clinical characteristics across providers." The MDP further notes on page 37, "developing measures that span settings - this might require adaptation or 'versioning' of the same measures." In response to the Senate Finance Committee's Chronic Care Policy Options memo released this past December, we argued that quality performance should be measured or rewarded based on both attainment and improvement together, or by attainment or improvement separately. At a minimum, this approach would be consistent with how CMS scores MSSP quality measurement performance.

This past year, the agency began to reward ACOs for quality improvement by adding additional points (up to four points) to an ACO's quality domain score if it demonstrated significant year-over-year quality improvement. AMGA encourages CMS to consider rewarding quality performance solely on the higher of attainment or improvement scores. This approach would appropriately help level the playing field for providers practicing at the far end of the demographic and socio-economic spectrum.

Patient Safety

"Safety" is identified as one of MACRA's five "quality domains." While patient safety has been a priority healthcare issue since at least the 1990s, patient safety experts such as Lucian Leape and Don Berwick have noted progress in eliminating medical errors has been frustratingly slow. Patient care, quality care, must be safe first and foremost. It is appropriate that the first "National Quality Strategy" goal is "making care safer." We strongly encourage CMS to make patient safety the agency's leading "strategic vision" priority. It is not listed as one of the 13 "strategic vision" priorities identified on pages 9 and 10.

One safety measure, for example, that deserves CMS' consideration for the MIPS measures, since the agency is attempting to lower spending growth via the mandatory Comprehensive Care for Joint Replacement (CJR) demonstration, is an evaluation of lower extremity joint replacement surgeries. Specifically, CMS should aggressively adopt a quality measure concerning the FDA's Unique Device Identification (UDI) system. CMS is well aware that the evaluation of the CJR-related Acute Care Episode demonstration showed savings were achieved through the purchase of cheaper, lower quality implants. The complications measure (NQF 1550) would be greatly improved by adding a UDI-related measure.

Population Health

"Population health" is another of MACRA's "quality domains." We have two related comments. First, on page 20, the MDP states that CMS will "adopt statistical risk adjustment models that account for differences in patient demographic and clinical characteristics." Per page 49, AMGA supports CMS' efforts to exploit NQF's research to incorporate socio-demographic factors into risk-adjustment. AMGA also encourages CMS to use the Assistant Secretary of Planning and Evaluation's (ASPE's) risk adjustment research findings that will be published this fall.

Second, there is no standard definition for the term "population health." CMS should define what "population health" means in order to determine what related quality measures will be designed and implemented. Absent a definition, CMS will be unable to identify coherently related quality measures and providers will have little idea how or why population health-related measures are being implemented.

The MDP does state on page 10 that CMS will, over time, include measures that "can produce results stratified by race, ethnicity, gender, and other demographic variables." AMGA strongly encourages this approach since disparities in healthcare delivery and outcomes can be dramatic. For example, a recent Brookings Institute study found that disparities in life expectancy nation-wide have grown substantially. The gap in life years between those in the top 10 percent of the mid-career income distribution compared to those in the bottom 10 percent has more than doubled from five to 12 years. AMGA also encourages CMS to coordinate its population health measures related to disparities with AHRQ's annual healthcare disparities report research.

Behavioral Health and Telehealth

Two of MACRA's five quality domains are "clinical care" and "care coordination." The MDP also addresses "mental health functioning" and "addictive behavior" on pages 33 and 34. Given this, AMGA supports improved integration of care for individuals with chronic disease combined with a behavioral health disorder. We shared this position in our Senate Finance Committee comment letter. It is estimated that less than half of Americans with a diagnosable behavioral or mental health illness receive any specific treatment. Only a third of these patients receive treatment that could be characterized as minimally adequate. We strongly encourage CMS to develop measures that demonstrate improved diagnosis and integration of behavioral health services.

CMS identifies telehealth in the agency's "gap analysis" and "care coordination" discussions on pages 7 and 32. The Medicare program has substantially lagged behind state Medicaid programs, the Veterans Administration (VA), and commercial plan usage of telehealth and remote monitoring services. For example, in 2015 Medicare spent less than $18 million on telehealth reimbursement. This spending represents .003 percent of overall Medicare programming. More than 30 states have telehealth coverage laws and several large national carriers including Aetna, Anthem, BCBS, Humana and UnitedHealthcare cover virtual physician visits in urban, suburban and rural areas. We strongly encourage CMS to exploit measures developed by these payors, the VA, and Medicaid to determine quality and cost effective use of telehealth and remote monitoring services.

The Therapeutic Relationship

The MDP does not address the importance of the therapeutic relationship between the provider and the patient (and family caregiver). Without a sound therapeutic relationship, research shows that there is little hope for achieving an optimal outcome. Under the MACRA mandated quality domain "patient and caregiver experience" discussed from page 33-34, the topic is unnamed. The final version of the

Health Care Payment Learning Action Network's (HCPLAN) "Alternative Payment (APM) Framework" white paper also does not address the therapeutic relationship in its "patient engagement" discussion. Instead, both discussions appear to place all the responsibility for the healthcare "experience" and "engagement" on the patient. The MDP notes "patient knowledge, skill and confidence for self-management" and the HCPLAN document defines the engaged patient as being, for example, "informed of their health status" and "easily able to access appointments and clinical opinions." Ultimately, healthcare quality is about one thing: the relationship the provider has with their patient or the qualities of interaction between the provider and the patient. To ignore measuring the quality of *the* fundamental aspect of care delivery is, also, a substantial oversight.

Retiring and "Topped Out" Measures

There is no mention in the MDP concerning how, if at all, CMS will retire so-called "topped out measures." For example, the "general" and "technical" principles on pages 19 and 20 simply states CMS will "develop measures in a rapid-cycle fashion" and "reorient and align measures." These statements are vague. These issues were discussed in context of the MSSP in the 2015 Physician Fee Schedule proposed and final rule. In that instance, CMS proposed and finalized a change in how scoring for topped out measures would convert to the use of a flat percentage. CMS also proposed 12 new measures and finalized eight. The final MDP should describe procedurally how CMS intends to address changes in its MACRA quality measure sets over time.

Measure Alignment

On page 7, the MDP discusses the applicability of measures across healthcare settings, i.e., using the same or similar measures or measure sets across healthcare settings. The MDP also states on pages 12 and 14 that CMS will draw on quality measures from existing programs, including PQRS, the Value-Based Modifier program (VM), and the Electronic Health Record (EHR) Incentive Program. With the exception of one MSSP measure used as an example of "care coordination" on page 32, the MSSP measure set receives no other mention. The Medicare Advantage (MA) measure set receives no mention whatsoever. We encourage CMS to employ MSSP and MA measures in the MIPS quality measure set, particularly since half of the ACO and Primary Care Medical Home (PCMH) measures that CMS recently announced via the agency's Core Quality Measures Collaborative were measures included in the current MSSP quality measure set.

Inter-relationship Between Quality Measures and Resource Use and Clinical Practice Improvement

The MDP notes "resource use" and "clinical practice improvement," which are two of the four MIPS component scores. The MDP states on page 8 that CMS "will consider clinical practice improvement activities in future updates to the MDP." However, the document provides no discussion of how the agency will inter-relate MIPS "quality measures" with "resource use" and "clinical practice improvement" measures. Since these three "merit based" metrics are inter-related or overlap, the MDP needs to describe how the agency will define these component scores in relation to one another. Further, the MDP must address how the agency will create synergy between and among all four MIPS component scores.

Collaborating on Measurement Development

The MDP notes on page 7 that CMS will "collaborate with specialty groups and associations." On page 22, the document also states CMS will consult with "national medical societies." We encourage CMS to consult with AMGA's data warehouse collaborative, Anceta. Anceta works in partnership with Optum in conducting comparative clinical analytics research. We are confident that Anceta can productively inform CMS' quality measurement development work.

Thank you for your careful consideration of our comments. AMGA is happy to discuss these further. Please contact David Introcaso, Ph.D., Senior Director, Regulatory and Public Policy at 703.838.0033, extension 335, with any questions.

Sincerely,

Donald W. Fisher, Ph.D.
President and CEO