January 30, 2020

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

Re: Quality Payment Program

Dear Administrator Verma,

The undersigned organizations are writing regarding CMS' MIPS quality measure selection and removal policy as finalized in the 2020 Physician Fee Schedule/Quality Payment Program (QPP) Final Rule. We appreciate the ongoing dialogue we have had with CMS to improve the Merit-based Incentive Payment (MIPS) program over the years but continue to have concerns with policies CMS has finalized and, welcome the opportunity to continue the conversation and work with CMS on solutions. While we generally support a more refined set of quality measures, we are particularly concerned with the direction of the Meaningful Measures Initiative due to the number of measures CMS removed from the 2020 MIPS program. We also have concerns regarding the new measure removal factor and the current approach to measure harmonization.

In addition, we oppose the new testing requirement placed on qualified clinical data registry measures (QCDR) in light of the short timeline provided to comply. Key to the success of MIPS and the transition to MIPS Value Pathways (MVPs) and reducing administrative burden is having a portfolio of appropriate quality measures that are applicable to each physician specialty to help improve the care of their patients. A specialty specific approach to measurement allows patients to make better assessments about care and helps create greater value and higher quality care.

Since the inception of MIPS, CMS has stated that it wants to reduce burden, encourage the use of reporting through electronic means, promote the use of qualified clinical data registries (QCDRs) and increase reporting on outcome and patient reported outcome measures. However, physicians and organizations are disincentivized to report through a QCDR or devote resources to measure development or QCDR development when there is no stability in quality reporting policies. The constant churn also increases physician burden and frustration with the MIPS program. For instance, it is difficult to justify spending millions of dollars on developing new measures when CMS finalized a policy to remove measures with low reporting rates after only two years in the program. The policy fails to acknowledge the time needed to adopt new guidelines and standards of care into practice. In addition, it takes time for sufficient data to be collected for benchmarking and tracking progress over time and physicians incur additional implementation costs. These challenges, as well as CMS' MIPS scoring policies, contribute to physician hesitation to adopt new quality measures. We believe that the field of performance measurement and our shared goal to improve the quality of care for patients are negatively impacted by these policy decisions.

We support a parsimonious inventory of meaningful, robust measures in the program and are committed to assisting CMS in developing and maintaining this inventory but are concerned that CMS is not applying consistent standards and rationales for selecting and removing measures. CMS specifically states that it is interested in outcome measures and as part of its annual review considers "whether the measure

removal will result in no remaining outcome or high priority measures available to a specialty to meet the quality performance category reporting requirements." However, CMS has removed several outcome and intermediate outcome measures. For example, starting in 2020 CMS has removed Measure 343, Screening Colonoscopy Adenoma Detection Rate, which is the only available outcome measure for gastroenterologists and is well supported by scientific evidence. The measure was also well suited to be part of a future MVP because there is a cost episode on colonoscopy and oncology has considered use of the measure to form an MVP on colon cancer.

In addition, CMS eliminated outcome Measure 192, Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures, a meaningful indicator to patients on whether a physician provides good quality care. In addition, we are very concerned with the potential for the measures used in MIPS to become increasing irrelevant to specialties and CMS must make determinations on measure removal with a broader lens. For example, with the removal of MIPS 328, 329, 330, and 403, no nephrology-specific measures remain within the program. **Therefore, we request CMS delay removal of measures in 2020 and instate a gradual timeline for removing measures as finalized in 2018.**

CMS must also be more consistent with its rationales for removing measures. In many instances, the feedback provided in the proposed rule cited one reason, but CMS stated something different in the final rule. CMS could also easily address many of the reasons it provides for removing measures through changes to its program policies and/or methodologies. For example, CMS often stated it is removing a measure in the proposed rule because the measure is designed as an inverse measure and CMS cannot benchmark the measure. However, inverse measures can be benchmarked, and organizations have put forward solutions to CMS to address the issue. CMS also includes inverse measures in other quality programs, such as the Hospital Value Based Purchasing program, so it is unclear why CMS has had trouble calculating similarly structured measures in MIPS.

CMS also frequently requests that developers harmonize their measures, but the request is often inappropriate. CMS recently requested that two measures from American Society of Plastic Surgery (ASPS), Tracking Operations and Outcomes for Plastic Surgeons (TOPS) registry and American College of Mohs Surgery, MohsAIQ registry be harmonized. Both measures were related to skin cancer but captured very different steps in the care process making harmonization impossible. Another measure that examined patient-report of emergency room or urgent care procedure-related visits within seven days of reconstruction after skin cancer was initially rejected due to a perceived overlap with an existing QCDR measure, which captures complications such as infection, bleeding or hematoma rates specific to excision. These two measures capture different procedures and have different intents. Furthermore, and as stated earlier, it is extremely difficult for physicians to create historic benchmarks if CMS changes, requires unnecessary harmonization, or removes measures on an annual basis. It is our belief that the only way to truly measure improvement and track data over time is to have a process in place that allows for longitudinal data collection and tracking.[1]

We also remain increasingly concerned with CMS' process for approving QCDR measures. Physician specialty organizations have devoted millions of dollars and significant time to the CMS QCDR deeming process, but the demands and policy decisions CMS has put in place make it increasingly difficult for organizations to maintain their registry in the MIPS program. The Congressional intent of allowing

[1] Albertini, John G., et al., Evaluation of a Peer-to-Peer Data Transparency Intervention for Mohs Micrographic Surgery Overuse. *JAMA Dermatol*. 2019;155(8):906-913. doi:10.1001/jamadermatol.2019.1259.

QCDRs to have custom measures was to enable clinicians to use measures from other quality improvement initiatives for MIPS reporting given the documented evidence that registry participation improves care.[2] For example, QCDRs use MIPS custom measures for maintenance of certification programs and research and analysis to support guideline development and quality initiatives as way to reduce physician burden and synchronize activities. Therefore, to truly move to "Meaningful Measures," requires a more thoughtful removal of measures, a process that does not seek to expeditiously remove measures unless truly warranted at this point, and one where harmonization decisions are made in ways that are clinically relevant. CMS should also continue working with QCDRs to increase their relevance.

While we understand CMS' desire to eliminate redundant measures and assess performance across broad subsets of clinicians, this approach alters the intent of using custom measures, seeks to combine measures that address similar topics but are meaningfully different and ignores the significant resources required to develop these measures. To ensure that unneeded changes to the measures within the program are minimized and only occur after a thorough review of evidence, consideration of potential unintended consequences that could result in patient harm, and other clinical considerations, measure reviews should only be made by individuals with the necessary clinical and measurement expertise. Therefore, **we encourage CMS to broaden its bench of clinical and measurement experts or consult with organizations such as PCPI to reduce this ongoing tension and problem.**

Furthermore, we understand CMS's desire that all QCDR measures demonstrate reliability and validity, but the new measure testing requirement will be difficult for QCDRs to adhere to, particularly as it relates to the short and infeasible timeline. There are legal delays, and it can take several months to execute a testing contract with a testing vendor. There are also a limited number of testing vendors and, due to the large number of measures now required to undergo testing, we are concerned testing vendors will be unable to support the increased demand. Therefore, **we have the following recommendations to handle the new testing requirement:**

- As an alternative to requiring full measure testing by Sep. 1, 2020, we recommend that CMS allow a grace period with existing QCDR measures. Some of the existing QCDR measures have been approved and in use for several years, up to as many as 6 years. Alternatively, measures that require testing could be prioritized based on uptake. For instance, measures reported by the majority of QCDR participants are tested first followed by the remaining measures in subsequent years.
- For new or substantially modified measures, we recommend CMS provide provisional approval for these measures for at least two years in use by QCDRs under MIPS, with the requirement that testing data be submitted the following year. This also would allow data to be collected on the measures and allow for more robust measure testing.
- We recommend a temporary exemption from testing requirements for any measure for which CMS requests harmonization or modification prior to use. Testing modifications prior to implementation would not be feasible given the timeline and should follow our same recommended policy on testing new measures.

Our recommended changes make the timeline to implement testing much more feasible as it takes substantial time to test measures, especially new measures for which there is no data readily available.

[2] Resneck, Jack., VanBeek, Marta., Physicians Respond to Accurate, Actionable Data on Their Performance. JAMA Dermatol. 2019;155(8):881-883. doi:10.1001/jamadermatol.2019.0845.

Additionally, our recommendations more closely align with the QCDR measure development cycles and will prevent unexpected measure disruptions for practices when there are modifications to a measure.

To assist with the financial hardship testing requirements are placing on physician-led QCDR stewards, **we would welcome the opportunity to discuss and work with CMS to consider alternatives to assessing reliability and validity from what is described in the CMS Measure Blueprint**. For instance, if CMS and QCDR stewards could work together to help build data sets it would have the potential to reduce costs and move us towards everyone's desired goal.

The policy changes CMS has made conflict with CMS' stated desire to ensure all specialties and subspecialties have access to applicable measures and are able to report in MIPS, as well as improve the care they provide. The recommendations provided above would strengthen and make the MIPS program more meaningful while also still encouraging the desired goal. We look forward to continuing to work with CMS to improve the MIPS program and increase the availability of clinically relevant measures that improve the quality of care for patients.

Sincerely,

American Medical Association
AMDA – The Society for Post-Acute and Long-Term Care Medicine
American Academy of Allergy, Asthma & Immunology
American Academy of Dermatology Association
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Otolaryngic Allergy
American Academy of Otolaryngology Head and Neck Surgery
American Academy of Physical Medicine and Rehabilitation
American Association of Orthopaedic Surgeons
American Association of Neurological Surgeons
American College of Allergy, Asthma and Immunology
American College of Cardiology
American College of Gastroenterology
American College of Physicians
American College of Radiology
American College of Rheumatology
American Gastroenterological Association
American Osteopathic Association
American Psychiatric Association
American Society for Clinical Pathology
American Society for Gastrointestinal Endoscopy
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Clinical Oncology
American Society of Plastic Surgeons
American Society of Retina Specialists
American Urological Association
College of American Pathologists
Congress of Neurological Surgeons

Endocrine Society
Heart Rhythm Society
Infectious Diseases Society of America
Medical Group Management Association
Renal Physicians Association
Society of Interventional Radiology
Spine Intervention Society
The Society of Thoracic Surgeons