March 1, 2016

Andrew M. Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS–3321–NC  
Mail Stop C4–26–05  
7500 Security Boulevard  
Baltimore, MD 21244–1850

Re: CMS Quality Measure Development Plan.

Dear Acting Administrator Slavitt:

The American College of Radiology (ACR), representing more than 36,000 diagnostic radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians and medical physicists, appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the draft CMS Quality Measure Development Plan (MDP).

The Medicare Access and CHIP Reauthorization Act (MACRA) has the potential to improve the delivery and outcome of care for Medicare patients. The ACR is committed to working collaboratively with the Centers for Medicare and Medicaid Services (CMS) and others to develop and share meaningful recommendations as regulations are prepared that will shape the delivery of health care services for years to come.

The ACR has previously provided a number of the comments contained in this document, but would like to reiterate these comments in the context of the Measure Development Plan.

I. Strategic Vision of the Measure Development Plan

Measure Integration to Support MIPS and APMs

MACRA encourages flexibility and a chance to redesign and overcome problems with existing value based payment programs. Consequently, the medical community would have serious objections to a new MIPS program that merely moves the current incentive programs without major modifications. Leading quality experts are also calling on CMS and payers to re-think the design of quality programs.
II. Operational Requirements of the Quality Measure Development Plan

Measure Development Funding

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 MIPS. MACRA also 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. Such entities shall include organizations with quality measure development expertise.”

This authorization is encouraging in that this will expand CMS’ ability to support the development of meaningful measures used by physicians who participate in new payment and delivery models designed to improve the quality and efficiency of care. An adequate library of appropriate quality measures that relevant to physician specialties and sub-specialties is key to achieving the legislation’s goals.

CMS must continue to address measurement gaps and to improve the existing set of measures. We reiterate our concern that CMS has not yet allocated MACRA-authorized funding toward this effort, and we urge the agency to do so as expeditiously as possible, and that a portion of those funds be used to support measure developers in electronic measure specification development and creation of interoperable electronic data transmission services across vendor systems. We also remind CMS of the importance of ensuring that measure development is evidence-based and clinician-led.

Part of the commitment by CMS to move towards improving the quality of care must also include the funding of measure testing, not just funding measure development. Measure testing allows for measure developers to not just test for validity and reliability, but to take into consideration real-world experience when developing and refining a measure.
The ACR believes that “organizations with quality measure development expertise” are organizations that have devoted substantial time and resources to developing and refining quality improvement and/or measure development activities. We also believe that preference should be given to organizations that meet the following pre-requisites:

- Quality measures are developed through a transparent process, which may include soliciting feedback from various stakeholders on measures under development;
- Measure information is shared with CMS as part of the QCDR reporting process;
- Measure descriptions and information on the measures is available to the public;
- Measure developers have experience and expertise with clinical quality measure standards currently in use (e.g., Quality Data Model, HL7, HQMF, eMeasure); and
- Developers are involved in or have deep knowledge of national efforts related to health care standards, such as clinical practice guidelines.

These characteristics will show integrity of developed measures to stakeholders, most importantly to patients and to the clinicians being measured. Developing measures through and with physician-led multi-stakeholder organizations will also enhance physician engagement and trust in the process and assist with the successful implementation of the MIPS program. A preference for experienced measure developers and stewards such as specialty societies and the Physician Consortium for Performance Improvement will support harmonization of measure sets across specialty societies’ clinical data registry activities, a reporting mechanism encouraged by MACRA. It will allow the profession to prioritize measurement efforts, coordinate activities, and ensure an inclusive process.

**Domains and Priorities**

While the purpose and goal of the National Quality Strategy is recognized as valuable, the requirement of reporting across three domains in the Physician Quality Reporting System (PQRS) has been a substantial increased burden for many physicians, even those with well above nine measures available to report. This is particularly true for radiology where many measures, both QCDR and PQRS, have been categorized in the patient safety or care coordination domains and many are sub-specialty or imaging modality specific.

We recommended that CMS remove domain reporting requirements. It is an arbitrarily high standard that often results in reporting for the sake of reporting and may do little to improve patient care. Maintaining reporting requirements does not recognize the comprehensiveness of the four MIPS categories and increases the total reporting burden. With the inclusion of the new Clinical Practice Improvement (CPI) category, some or all of the activities captured though this category may be more meaningful and accurate representations of quality than the current set of PQRS quality metrics.

Additionally, it is often challenging and at times arbitrary to assign one domain to a measure; measures have been moved across domains from year to year. The assignment to domains has
not been completely transparent. CMS should allow stakeholder input into domain
determinations; at the very minimum, the measure steward should make recommendations.
CMS should allow measures to serve in multiple domains to ensure physicians within each
specialty have an adequate suite of measures to meaningfully participate and comply with the
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Consequently, we recommend that CMS consider doing away with the domain requirement and
not carry that through to the Clinical Practice Improvement Activity categories in MIPS. Instead
use domains and categories to simply guide measuring national quality goals.

Clinical Practice Improvement (CPI) Activities

CMS should allow for the broadest interpretation of CPI activities possible and, simultaneously,
work with stakeholders to identify best practices based on community and population needs.
Choice of activities should be optional. No category should be mandatory.

Physicians and other eligible professionals should be given credit for CPI activities in which they
are currently engaged, including those that are mandated or encouraged by Medicare and other
government programs. These may also include activities recommended by a certifying medical
specialty board as quality improvement activities for Maintenance of Certification Part 4. This
would include a long list of activities such as:

- Participation in a QCDR and registries run by other government agencies such as FDA or
  private entities such as a hospital, or medical specialty.
- Stewardship to promote imaging appropriateness among ordering physicians
- Leadership and participation in protocol optimization and management
- Participation in survey for Diagnostic Imaging Center of Excellence (DICOE) Program,
  or stewardship of group to attain DICOE status
- Participation in relevant practice improvement activities facilitated by each state’s
  Quality Improvement Organization.
- Leadership or participation in a local clinical quality improvement activity
- R-SCAN

Other activities that should be considered:

- Activities that develop infrastructure for the performance of accountability measures,
such as collaborating with an EHR vendor to enable participation in a QCDR.
- Participation in designated private payer CPI activities.
- Various activities of organizations representing physicians and medical groups should
  also be recognized as practice improvement. This would include accredited continuing
  medical education, board-certification-related activities and other initiatives aimed at
  improving practice.
Administration of CAHPS or other patient experience and satisfaction surveys should be considered as a CPI activity rather than a quality measure.

Challenges in Quality Measure Development and Potential Strategic Approaches

Shortening the Timeframe for Measure Development

CMS describes its experience and use of Lean design principles as a method for reducing the timeframe for measure development. However, the ACR believes that the time to develop, propose for use, and implement a measure into a program is still too long. And the organizational resources required for going through those stages is substantial. Multiple stages in the measure development timeline and lifecycle are not clearly streamlined or examined. We recommend that CMS routinely track the time it takes to develop a measure from beginning (CMS issues measure development funding) to end (first year a physician may report on the measure) to determine where delays occur and to estimate cost for measure developers. The time tracking process must also include the time required to test, certify, and re-certify electronic clinical quality measures (eCQM).

Measure Application Partnership (MAP): The MAP process adds value by providing multi-stakeholder input for CMS programs. Yet, requiring that measure developers propose measures to the MAP for use in CMS programs introduces another time-consuming step in the measure development cycle. MACRA provides CMS some flexibility in how it uses the MAP. We make the following improvement recommendations in regards to the MAP:

- Voting options on individual measures do not correspond with the early state of the vast majority of measures under review;
- The MAP treats measures undergoing maintenance/updates as if they are under development despite the fact that CMS has data about and experience with the measure, which, if shared, could lead to a more focused and meaningful discussion;
- Stakeholders often only have one-week to thirty days to comment on MAP recommendations—depriving stakeholders and the programs of a thorough review and constructive feedback;
- The deliberations of the MAP coordinating committee and workgroups are highly dependent upon who has a seat at the table. If a measure within a particular specialty area is being reviewed, and that specialty is not represented on the committee or workgroup, legitimate issues may be overlooked and measure review may be inadequate; and
- Notices of opportunities for measure developers or stakeholders to publicly comment are sometimes inadequate. Agendas are all too often unavailable until or close to the day of a MAP meeting. The order of review of items on the agenda frequently deviates from the published schedule, making it difficult for those not present, including clinicians and the public, to participate or provide comments.

The ACR looks forward to continued dialogue with CMS officials about these and other issues affecting radiology. If you have any questions or comments on this letter or any other issues please contact Judy Burleson at 800-648-3787 or via email at jburleson@acr.org.
Respectfully Submitted,

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