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Submitted via electronic form to: *https://www.p4qm.org/guidebook/PRMR-MSR/Guidebook-of-Policies-and-Procedures-for-PRMR-and-MSR*

July 28, 2023

Nicole Brennan, MPH, DrPH
Director
Battelle's Partnership for Quality Measurement
PQMSupport@Battelle.org

RE: Comments on Guidebook of Policies and Procedures for Pre-Rulemaking Measure Review and Measure Set Review

Dear Dr. Brennan:

The AAMC (Association of American Medical Colleges) appreciates the opportunity to respond to the Partnership for Quality Measurement (PQM) "Guidebook of Policies and Procedures for the Pre-Rulemaking Measure Review (PRMR) and Measure Set Review (MSR)" as part of the consensus-based entity (CBE) contract with the Centers for Medicare & Medicaid Services (CMS). The AAMC has participated in the pre-rulemaking measure review process, as required under the Patient Protection and Affordable Care Act of 2010 (ACA), since its inception, and the Association believes strongly in the value of evidence-based recommendations from a group of engaged stakeholders to CMS on the selection of quality and efficiency measures under consideration (MUC) for use in CMS programs. The AAMC served as an organizational member of the Measure Application Partnership (MAP) Clinician Workgroup from 2011-2017 and the Hospital Workgroup from 2017–2022, providing the unique quality and efficiency measurement perspectives of academic medicine.

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members are all 157 U.S. medical schools accredited by the Liaison Committee on Medical Education; 13 accredited Canadian medical schools; approximately 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools and teaching hospitals and the millions of individuals across academic medicine, including more than 193,000 full-time faculty members, 96,000 medical students, 153,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened the AAMC's U.S. membership and expanded its reach to international academic health centers.

The AAMC is committed to working with the PQM on refining the policies and procedures for the PRMR and MSR to ensure that it is successful in meeting its goal to ensure measures on the

MUC List are reasonable and appropriate to CMS programs and target populations. To this end, we make the following comments and recommendations.

Increased Public Engagement Requires Additional Time for Reviewing the MUC List and Submitting Public Comment

The ACA requires the MUC List for future rulemaking be published annually by December 1. Under the prior pre-rulemaking review process, due to its cascading committee structure, there typically was a very brief comment period (around 7 days) ahead of Equity and Rural Committee meetings and Working Group meetings in mid-December, and a final Coordinating Committee meeting in January. The Guidebook establishes a new structure that allows for a longer public comment period. The new structure removes the Coordinating Committee and stand-alone committees evaluating measures specific for rural health and health equity, and instead retains only three setting-specific Committees: Hospital, Clinician, and Post-Acute Care/Long-Term Care. This simplification allows Committee meetings to be held in January, allowing greater time for public engagement in December.

Specifically for public engagement, this structure allows the PQM to set a 21-day public comment period commencing with the release of the MUC List, in addition to public Listening Sessions with staff and measure developers/stewards to address questions prior to the deadline to submit public comment. The PQM then will post public comments received and notes from the Listening Sessions to the PQM website within five days of the close of the public comment period, allowing greater transparency for all stakeholders. **The AAMC supports this approach to allow greater time for measure evaluation and to prepare feedback. We agree it is likely to increase public engagement with the MUC List in advance of the January recommendation meetings.**

Recommendation Groups Assessing the MUC List Must Represent a Diverse Set of Stakeholder Perspectives and Include Expertise on CMS Programs

As previously noted, the PQM proposed a streamlined committee structure for the PRMR, with three setting-specific Committees. Additionally, the PRMR will use a Novel Hybrid Delphi and Nominal Group (NHDNG) technique to bring both a multi-step review process and additional opportunities for stakeholders to meaningfully participate with the pre-rulemaking measure review. Under the NHDNG, roughly 60 people would serve on a setting-specific Committee, with 35-45 people assigned to serve on the Advisory Group and 18-20 on the Recommendation Group. Only those assigned to the Recommendation Group for a given MUC List cycle would provide input on and ultimately vote on the overall recommendations that the PRMR will deliver to CMS.

Of great concern to the AAMC is that the draft Guidebook suggests that only certain types of "Roster Categories" of individual Committee Members can be selected for the Recommendations Group. On page 10, there are examples of Roster Categories that can serve as Members of either the Advisory Group or the Recommendation Group, with only providers and purchasers listed as Roster Categories that can serve on both Groups. It further notes that the

PRMR prefers Members who possess a system-level perspective, including professional associations and researchers, serve on the Advisory Group, whereas those Members who are most likely to be impacted by the implementation of quality measures serve on the Recommendation Group. This contrasts with a July 10th webinar on the PRMR and MSR that included a table of eligible Roster Categories, and the target number of individuals from each category for the PRMR Advisory and Recommendation Groups on slide 26.[1]

The AAMC strongly objects to the description of Committee Member Roster Categories being limited in Committee participation as drafted in the Guidebook. We believe that professional associations and specialty societies provide a voice for both the system-level perspective and the perspective of those who are most likely to be impacted by implementation of quality metrics. Professional associations and specialty societies can engage many clinicians and facilities across the country and obtain widespread feedback necessary to provide a unique, diverse perspective on the MUC List. We also believe that if the Recommendation Group has sole voting power on the recommendations to CMS, such group must include Roster Categories with expert understanding of CMS quality reporting and performance programs to ensure that recommendations best evaluate the MUC List relative to each CMS Program. The Guidebook, as drafted, appears to *expressly limit* participation in Roster Categories of representatives with broad system-level perspective, including understanding the design of CMS quality programs, to the non-voting Advisory Group.

Recommendation: **The PQM should ensure that the Guidebook fully reflects that all Roster Categories of Committee Members, including Professional Associations and Specialty Societies, can serve on both the Advisory and Recommendation Groups.**

Reconsider the Random Assignment and Rotation of Committee Members to Either the Advisory Group or the Recommendations Group

The Guidebook and the July 10th webinar both describe a three-year limit to an individual's term on a Committee,[2] and a process whereby individual Members of the Committees will be randomly assigned to either the Advisory or Recommendation Group for a given MUC List cycle. Through this process, an individual Committee Member would serve at least once on the Recommendation Group in a three-year term. Once assigned for a cycle, an individual could not serve concurrently on both the Advisory Group and Recommendation Group.

The AAMC is concerned that this random assignment and rotation process may limit the effectiveness of the PRMR. Our experience from serving on and observing the prior MAP process tells us that the intricacies of voting procedures and capturing consensus through public dialogue improves as the Committee members gain experience. As proposed, random assignment between Advisory Group and Recommendation Group annually will frustrate continuity for individuals over their 3-year term serving on a Committee. Each cycle, PQM staff will likely

[1] Slide 26, Roster Categories and Target Number of Individuals for PRMR and MSR (July 10, 2023).
[2] Recognizing the initial formation of the PRMR Committees, the Guidebook details a staggered term process initially, so that there can be an annual Committee Roster nominations process and allow for one-third of the individuals on a Committee to rotate off the Committee annually.

need to start anew at training and framing the review cycle, Recommendation Group facilitated discussions, and Recommendation Group voting procedures, which in turn might blunt the effectiveness of the PRMR's deliberations and ultimate recommendations to CMS.

Recommendation: **The PQM should reevaluate the overall effectiveness of an annual reshuffle of individual Committee members across the Advisory and Recommendation Groups during the three-year term.**

Committee Members on the Advisory Group Should Have the Opportunity to Vote on Recommendations for Full Engagement and Transparency

As drafted, only Committee members assigned to the Recommendation Group for an annual MUC List review cycle will have the opportunity to vote on the final recommendations provided to CMS. Limiting the number of Committee Members with a full say on the recommendations does not fully capture Committee Member perspectives for CMS.

Recommendation: The PQM should allow members assigned to the Advisory Group to vote on the recommendations, and such results should be included in the final report to CMS to ensure full Committee vetting is transparently recorded.

The Meaningfulness Measure Review Criterion/Assertion Should be Broken Out into Multiple Criteria/Assertions to Best Provide Tangible Recommendations to CMS

The Guidebook, on page 19, lays out four PRMR Criteria/Assertions for evaluating the evidence provided on a given measure for its intended use in a specific CMS Program for a specific population. Those four Criteria/Assertions are: (1) Meaningfulness (Importance, feasibility, scientific acceptability, and usability criteria met for measure considering the use across programs and population), (2) Appropriateness of scale – Patients/recipients of care (measure is implemented on patients/ recipients of care appropriate to the purpose of the program), (3) Appropriateness of scale – Entities (measure is implemented on entities appropriate to the purpose of the program), and (4) Time to value realization (measure has plan for near- and long-term positive impacts on the targeted program- population as measure matures).

The AAMC believes that the Meaningfulness criterion/assertion is too broad for a single, equal review metric relative to the other three criteria/assertions. Whereas the other criteria/assertions largely evaluate a single component, the Meaningfulness criterion/assertion include four critical components pivotal to the evaluation of a measure. These four components were standalone elements for consideration under the prior Consensus-Based Entity's measure evaluation framework for measure endorsement. As currently drafted, it appears that a measure that is not feasible to implement, or that does not meet acceptable measurement standards for validity or reliability, could still "pass" the overall Meaningfulness criterion if there is complete and adequate evidence of the measure's usability and importance.

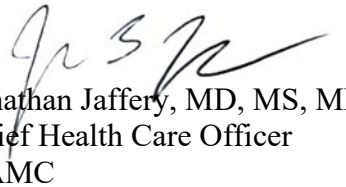
Recommendations: The PQM should clarify whether the four Criteria/Assertions are equally weighted for considering the Overall recommendation and should break out the Meaningfulness criterion/assertion into at least two criteria/assertions to ensure all

components of the criterion/assertion are appropriately evaluated and addressed when forming a final recommendation to CMS.

Conclusion

The AAMC thanks the PQM for the opportunity to provide input on this important effort to come together to build the PRMR and MSR to best provide meaningful feedback on measures for CMS Programs. We would be happy to work with you on any of the issues discussed above or other topics that involve the academic medicine community. Please contact my colleagues Gayle Lee (galee@aamc.org) and Phoebe Ramsey (pramsey@aamc.org) with any questions about these comments.

Sincerely,



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Cc: David Skorton, MD, AAMC President and CEO