

The American Medical Association (AMA) appreciates the opportunity to comment on the proposed changes to the endorsement and maintenance process, particularly Appendix H, Measure-Specific Guidance. The AMA is extremely concerned to see some of these revisions in the absence of a process that is transparent on process to obtain input, the individuals consulted, and how recommendations were reached. Our comments on Appendix H are outlined below.

#### H1. CBE Policy on Pediatric Clinical Quality Measures

We do not support the use of generative artificial intelligence to create an initial draft of any policy that would be used to evaluate the appropriateness of measures and were surprised to see that the PQM determined that this process would yield a decision that is logical and clinically appropriate. We disagree with the assumption that it is appropriate to extrapolate data using adult patients to the pediatric population in any instance. Limitations are already in place to ensure that measures are used for only the specific level of measurement and setting of care for which a measure is specified and tested, and a similar constraint is appropriate to apply to patient populations.

#### H2. CBE Requirements for Electronic Clinical Quality Measures (eCQMs)

While the AMA supports every effort to ensure that eCQMs are sufficiently evaluated for feasibility and scientific acceptability, we are concerned that the proposed changes will not be adequate to produce the desired goal. First, we are opposed to the clarification that is made on page 62 of the draft guidebook:

“A new eCQM version of an existing endorsed [non-eCQM] measure is automatically considered to be endorsed.”

While the importance of the measure will not change, the assessments on the feasibility, scientific acceptability, and use/usability will differ due to the existing challenges with collecting data for electronic health record systems (EHRs). We urge PQM to reconsider this statement.

In addition, it would be helpful to understand why the additional requirements focus on the number of sites within one vendor system rather than expanding the number of systems on which feasibility and scientific acceptability assessments are completed. Ongoing experience with eCQMs demonstrate that the current process of using data from at least two or more systems does not adequately identify potential challenges with data capture and extraction or the accuracy and completeness of the data elements. We believe that focusing on increasing the number of sites using a specific vendor system, only requiring data element reliability and validity testing in one vendor system for initial endorsement, and gap and measure score reliability and validity testing in at least two systems in a

minimum of two systems for maintenance reviews will not improve our ability to determine how well an eCQM may or may not perform. Proposing to make these changes effective within the next few months does also not provide sufficient time for measure developers to be responsive and may prove costly for those who are preparing to submit measures in the next cycle based on the previous requirements.

Before any additional guidance for eCQMs is finalized, we urge the PQM to convene a group of clinicians, practices, hospitals, accountable care organizations, EHRs vendors, and others to create reasonable expectations and a timeline that will further our ability to improve the accuracy and completeness of EHRs data for these measures.

### H3. Instrument-Derived Measure Set Submission Framework

We were unable to determine whether this guidance would allow measure developers to use tools or instruments that have not been sufficiently tested. The AMA believes that it is important for these types of measures used for accountability purposes to rely on surveys or other tools that have been demonstrated to produce reliable and valid results. We recommend that this requirement be explicitly included in this guidance.

### H4. CBE Guidance on Entity-Level Reliability

PQM appears to be further limiting the type of testing that can be completed to demonstrate this level of reliability. We believe that decisions on what method of testing should be left to the measure developer to determine rather than PQM limiting what can be considered acceptable. We also note that there is little to no information on why this decision was necessary and how any discussions resulted in these specific methods. We urge the PQM to be more transparent on the process, individuals consulted, and justification for the final decisions.

### H5. CBE Guidance on Entity-Level Validity

While the AMA does not have any concerns with the clarifications provided, we note that this section is lacking detail on the process, individuals consulted, and justification for the final decisions. We believe that this transparency is vital to ensuring full understanding of and trust in the decision-making process.

### H6. CBE Guidance on Cost Measures

The AMA believes that it is imperative that any evaluation of a cost measure must include an assessment of its usefulness and accuracy within the context of quality, and we support the inclusion of the first principle affirming this need. We would recommend that the PQM consider whether additional guidance ensuring that any analysis of this relationship uses measures that have the same attribution approaches or models. For example, the cost

measures used in the Merit-based Incentive Payment System (MIPS) often attribute patients to more than one physician and/or may leverage different approaches (e.g., plurality of charges vs. plurality of visits), while physicians and practices will have different patients assigned to them for the quality measures included in the correlation. These types of correlations have been used in the past and we believe that this lack of consistency across measures will provide inaccurate conclusions.

Thank you for the opportunity to comment.