

August 8, 2011

Donald Berwick, MD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Availability of Medicare Data for Performance Measurement; Proposed Rule; 76 *Fed. Reg.* 33,566; (June 8, 2011); CMS-5059-P

Dear Administrator Berwick:

The undersigned organizations appreciate the opportunity to provide our views concerning the Centers for Medicare and Medicaid Services (CMS) proposed rule on *Availability of Medicare Data for Performance Measurement*. This proposed rule implements section 10332 of the *Patient Protection and Affordable Care Act* (the ACA).

It is critical that the data release program under section 10332 get off the ground in a positive manner. It is from this perspective that we sincerely appreciate CMS' efforts on this proposed rule and the agency's desire to implement the proposed rule in a manner that closely tracks important safeguards included in the statute. These safeguards are critical for ensuring that public reports are valid, reliable and actionable for patients, physicians, and all stakeholders. Several critical issues must be resolved for physician measurement and public reporting to be effective. There must be a method for ensuring that any publicly reported information is: (i) correctly attributed to those involved in the care; (ii) appropriately risk-adjusted; and (iii) accurate, user-friendly, relevant, and helpful to the consumer, patient, physician or other stakeholder. If done correctly, public reporting has the potential to help provide appropriate and accurate information to patients, physicians and other stakeholders that can improve quality at the point of care. If not approached thoughtfully, however, public reporting can have unintentional adverse consequences for patients. For example, patient de-selection can occur for individuals at higher-risk for illness due to age, diagnosis, severity of illness, multiple co-morbidities, low literacy level, or economic and cultural characteristics that make them less adherent with established protocols. Programs must be designed so that appropriate and accurate information is available to patients to enable them to make educated decisions about their health care needs.

Moreover, an important aspect of a quality reporting program is that physicians have the opportunity to review their data that forms the basis for any public report. Physicians and other providers must have the opportunity for prior review and comment, along with the right to appeal, with regard to any data or its use that is part of the public review process. Any such comments should also be included with any publicly reported data. This is necessary to give an accurate and complete picture of what is otherwise only a snapshot, and possibly skewed or outdated view of the patient care provided by physicians and other

professionals or providers. CMS should also undertake a detailed educational program for the public to explain the Medicare data release program and openly address its limitations, including barriers to physician participation in quality programs and the fact that quality measures used by qualified entities in the program take into account only a small fraction of all dimensions that explain overall physician performance.

In recognition of many of the foregoing critical factors that must be resolved regarding making performance information public, Congress included a number of requirements in section 10332 that mirror those listed above, and these requirements are discussed at length below. **As CMS moves forward to implement section 10332, we urge CMS to carefully develop a final rule in which qualified entities: (i) meet each of the requirements in section 10332; (ii) produce public reports that are valid, meaningful, actionable, and user-friendly; and (iii) participate in a reporting program that is standardized and streamlined to minimize administrative burden and allow comparable results. We urge that CMS move toward standardization of many elements qualified entities will use in developing and releasing public reports, including standardization of: measure specifications; the content of public reports; formatting of the reports; risk-adjustment and attribution methodologies; and appeal processes. It is also critical that the standardization process be applied across all payers, including Medicare and private payers.**

We recognize that the data release program is in its infancy, and the undersigned organizations wish to work with CMS, as we move forward, to fully achieve the vision of standardization in physician measurement and quality improvement programs. Without it, public reports will not only be confusing, they will be misleading, not actionable, and even potentially harmful. In short, they could undermine rather than improve quality. CMS must also ensure that this new data release public reporting program is aimed at quality improvement and not initiated simply for measurement sake. The ability to add Medicare claims to other types of payer data should be aimed at helping physicians in their efforts to improve quality at the point of care. Further, the data used to profile physicians must be based on the quality of care provided, and never on utilization of resources alone.

Physician Attribution, Risk Adjustment Methodologies and Other Critical Factors Required for Publicly Reporting Performance Information

Under section 10332, qualified entities are required to include in public reports an understandable description of the quality measures used, as well as the rationale for use of any Secretary-approved alternative measures, risk adjustment methods, physician attribution methods, other applicable methods, data specifications and limitations, and the sponsors. Further, qualified entities must submit to the Secretary a description of the methodologies that the qualified entity will use to evaluate the performance of providers and suppliers. **We urge CMS to clarify in the final rule that these descriptions are required for Medicare and private payer data, and that the methodologies used by qualified entities are standardized across Medicare and private payer data.**

We are disappointed that CMS did not address in the proposed rule any specific details for risk adjustment and attribution model specifications that qualified entities must employ to

ensure that entities are using adequate and effective risk adjustment and attribution techniques. Although the statute requires qualified entities to describe their methodologies, this does not preclude CMS from setting forth specifications that the qualified entities must meet. **We urge CMS to provide in the final rule specifications that qualified entities must meet in applying strong, effective, and adequate risk adjustment and attribution techniques. We also urge that CMS ensure that adequate risk adjustment and attribution models are developed, widely tested, and applicable before qualified entities may make reports publicly available. Attribution and risk adjustment methodologies should be assessed on a condition-specific basis, and should be based on physician and other expert input, and transparent to all stakeholders. Once these techniques are in place, we urge that CMS exercise strong oversight to ensure that these requirements are met on an ongoing basis.**

Physicians and patients must be able to trust the quality performance determinations presented in these reports, and not have to decipher conflicting reports that present different conclusions due to a lack of applying accurate, transparent, and consistent risk-adjustment and attribution methods. Without standardization of risk-adjustment and attribution methods, there inherently will be multiple and conflicting performance reports for the same physician. This will undermine the goals of public reports resulting in actionable determinations by patients and physicians, as well as improved quality of care.

Finally, in implementing section 10332, it is urgent that CMS ensure that qualified entities properly explain the data specifications and limitations and the sponsors (as required by this provision and set forth in the proposed rule) so that the public can properly assess the data.

Use of Standard Measures Required for Analyzing Data

CMS proposes to implement the statutory requirement that qualified entities are required to use “standard” measures or “alternative” measures if the Secretary in consultation with the appropriate stakeholders determines that the use of these “alternative” measures would be more valid, reliable, and responsive to consumer preferences, cost effective, or relative to dimensions of quality and resource use not addressed by “standard” measures.

At a time when health care payers, providers, and consumers are looking to better align and integrate the measures, reporting criteria and time periods for public and private quality incentive programs, moving toward standardization of measures used in quality programs across all payers, including Medicare, is critical. The use of “alternative measures” will create confusion about what constitutes a “standard” measure. Further, if one payer uses a “standard” measure and another uses an “alternative” measure with respect to similar services, this will create even more confusion. Reports will not allow for accurate comparisons, and they will be indecipherable and unreliable for patients, and not useful for physicians in their efforts to determine how best to improve health care quality.

We recognize the statute provides for the use of “standard” and “alternative” measures. We urge CMS, however, to ensure a rigorous process by which qualified

entities must prove that an “alternative” measure meets the statutory threshold, *i.e.*, that it is “more valid, reliable, and responsive to consumer preferences, cost effective, or relevant to dimensions of quality and resource use not addressed by such standard measures.” CMS should also ensure adequate consultation with physicians and other appropriate stakeholders, as required by the statute, in determining whether an “alternative” measure meets this threshold. Moreover, we urge CMS to require that these “alternative” measures be used only on a provisional basis until they can be endorsed through the NQF within a certain timeframe *e.g.*, 12-18 months. This will help avert multiple NQF-like processes and multiples sets of differing measures, which would dramatically increase administrative burden and confusion, leading to invalid results.

Section 10332 also requires qualified entities to use Medicare data along with claims data from private sources in their public performance reports. **It is critical that CMS provide standardized specifications for the measures that may be used with Medicare and non-Medicare, private health plan data. This is to ensure that consistent measures and analytics are used in developing public reports that are valid, reliable, and actionable.**

Finally, section 10332 requires that qualified entities must be qualified to use claims data to evaluate the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use. **We urge CMS to recognize the complexities involved in efficiency measurement.** Currently, there are no accepted standard cost efficiency measures, although the Physician Consortium for Performance Improvement (PCPI) and other entities are working to develop them. While there are cost efficiency measurement programs, these are known to be extremely inaccurate. **Accordingly, we urge that CMS use extreme caution if it adopts an efficiency or cost measure as an “alternative” measure. In addition, since the statute does not specify that performance evaluations must include each of these types of measures, we urge CMS, in initial program years, to limit performance evaluations by qualified entities to quality measures, and not measures of efficiency, effectiveness, and resource use.**

Standardization of Format of Public Reports

Under section 10332, prior to releasing public reports, a qualified entity must submit to the Secretary the format of the public reports. **We support CMS’ proposal to require qualified entities to submit to CMS prototype reports at the time of their application to become qualified entities.** We encourage CMS to maintain this requirement in the final rule, as producing prototype reports should not be problematic for applicants with sufficient expertise in working with claims data and performance measures. This will also give CMS the opportunity to review the prototypes to ensure that the reports can be easily understood and used by providers.

CMS also proposes to allow qualified entities to modify initial prototype reports, so long as it occurs within the deadlines laid out in the proposed rule. This implies that qualified entities will be permitted to have varying types of public reports. **We urge CMS to consult with key stakeholders, including the physician community, to develop**

standardized formats for the public reports that are relevant, meaningful, and user-friendly. Varying reports will create confusion, be difficult to compare, and increase the administrative burden for physicians, the public, and other stakeholders that use these reports.

In the event that CMS does not create a standardized report, we alternatively urge CMS to allow physicians and other affected providers/suppliers to petition CMS to require a particular qualified entity to modify the prototype for the entity's public report. In the proposed rule, CMS states that reports must contain language to describe the data and results, including an easily comprehensible description of the proposed measures, the rationale for the use of those measures, a description of the methodologies to be used, and a description of the data specifications and limitations. **It is critical that the content of the reports meet these requirements, and that physicians and other providers/suppliers have the opportunity to provide input on whether these requirements have been met.**

In addition, the AMA is creating a draft set of Standards for Reporting Physician Data. These standards are being shared with health insurers and the Federation of Medicine to reach consensus on the best way these types of data are reported. **Once they are finalized, we believe these standards could serve as a basis for all programs reporting these types of data.**

Review and Appeals Prior to Public Release of Reports

Section 10332 establishes that qualified entities are required to confidentially provide public reports to physicians or other providers/suppliers to be identified in the report, **prior to the public release of the report, and with an opportunity to appeal and correct errors.** Qualified entities must also make available to physicians and other providers/suppliers, upon request, data made available under section 10332.

To meet these statutory requirements, CMS proposes to require that applicants include a plan for their process for confidential report review, appeals, and error correction processes in their application materials. Qualified entities would also be required to describe the means by which providers of services and suppliers may request the Medicare data that was used to calculate the performance measures they wish to appeal and correct. CMS also sets forth in the proposed rule several elements that applicants for qualified entities must meet in their plans to achieve these goals. **We support a strong process for confidential report review, appeals, and error correction, as well as a process by which providers of services and suppliers may request the Medicare data that was used to calculate the performance measures. We urge CMS to strengthen the proposed review, appeals, and error correction process in accordance with our comments below.**

Confidential report review, appeals, and error correction

We applaud CMS' discussion in the proposed rule that to the greatest extent possible, explanations and information should be written using a language and formats that are as

easily understood as possible. We also believe that reports and methodologies should also be easy to access and clearly formatted.

We urge CMS to ensure stringent overview of the review, appeals, and error correction process to ensure it is meaningfully and effectively established and enforced. This is necessary to address lessons learned from the BQI pilots. We also urge CMS to require qualified entities to include physicians' comments in the public reports. Further, physicians should also be able to utilize the appeals process after reports are made public, especially in the event that an error occurs after the physician has had an opportunity to review the public report.

CMS also states in the proposed rule that it does not have the statutory authority to require qualified entities to share non-Medicare claims data with providers and suppliers, upon request to correct an error or appeal their results. We urge CMS to clarify this statement. It seems clear from this discussion that CMS' view is that the agency can only require qualified entities to provide Medicare data upon a physician or provider/supplier request, but that CMS does not have the authority to extend this requirement to non-Medicare data. Yet, it is unclear from this discussion whether CMS is proposing that the review, appeals, and correction process applies to both Medicare and non-Medicare data, or just to Medicare data. **We urge CMS to clarify in the final rule that the review, appeals, and error correction process applies to both Medicare and non-Medicare data. We further urge CMS to require that qualified entities share Medicare and non-Medicare data upon request by a physician or other provider/supplier.** Under section 10332, Congress provides CMS with the authority to require qualified entities to include non-Medicare data when evaluating the performance of physicians and other providers/suppliers. Congress also requires CMS to ensure that qualified entities' public reports be made available confidentially to physicians and other providers/suppliers, prior to public release of the report, and with an opportunity to appeal and correct errors. This requirement applies to the entire report, which would include Medicare and non-Medicare claims data. Further, since we believe Congress intended to provide CMS with the statutory authority to subject Medicare and non-Medicare data to the review, appeals, and correction process, it would not make any sense for CMS to not have the authority to require qualified entities to provide the data, including non-Medicare data, needed by physicians and providers/suppliers to exercise their review, correction and appeal rights. If physicians and providers/suppliers do not have access to the data, then the review, appeals, and error correction process is meaningless.

Physician input and verification of patient data

Reports and scores generated from the release of data to qualified entities must have physician input and verification that the information is generated from patients the physician has actually treated. CMS is proposing that qualified entities would be required to provide names of beneficiaries upon request on a case-by-case basis. **While patient privacy and data security are extremely important issues, we urge CMS to choose option one in the final rule, which would require qualified entities to provide a list of patient names to physicians so they can verify if the scores or reports generated are linked to services provided.** Without this level of detail, it will be difficult, if not impossible, for physicians to interpret their results or know which measurement results to

appeal, and they will be unable to check the qualified entity's results against their own data and results. Further, physicians and other stakeholders will question the accuracy of the information, and physicians will not be able to use the analysis generated to improve quality for that physician's patient population. Providing patient names will also help protect the public against false information that may wrongly damage a physician's professional reputation. In addition, physicians should automatically be provided with patient names, and should not have the added burden, along with the time delays, involved in requesting beneficiary names on a case-by-case basis.

Standardization of process for confidential report review, appeals, and error correction
We urge CMS to ensure standardization of the process for confidential report review, appeals, and error correction across qualified entities. This will help to minimize administrative burden for physicians who may have to use these processes across various qualified entities.

Timelines for Appeals and Error Correction
CMS must ensure that feedback loops for review and correction of performance reports are timely and standardized across qualified entities. The proposed rule is not crystal clear on what timely and standardized feedback loops should be established for appeals and error corrections across all qualified entities. Without specified requirements from CMS, it will be difficult for physicians and patients to have faith in the usefulness and accuracy of these new performance reports. Further, without clear and timely feedback loops between CMS and qualified entities, and between qualified entities and physicians, the ability of qualified entities, CMS, physicians, and suppliers to benefit from this program will be seriously compromised. For example, not allowing appropriate time to review the report prior to its release to the public could result in the dissemination of inaccurate performance reports, which could harm patients as well as a physician's reputation. Moreover, without clear timelines about the review processes for these reports, there may be insufficient time for resolution of disagreements between providers and the qualified entity—resulting in the proliferation of performance reports that are highly disputed and therefore irrelevant for use in quality improvement or public reporting determinations.

CMS is proposing that qualified entities will be required to share performance reports with physicians and other providers/suppliers at least 30 business days prior to the public release of data. Physicians and other providers/suppliers would then have at least 10 business days to make a request for data and an additional 10 days to request an error correction. **These proposed timeframes do not provide physicians with sufficient time to review the data and appeal their result.** They also do not allow qualified entities enough time to resolve appeals prior to the public reporting of performance information.

We strongly support the provisions of the program that allow providers to review their performance metrics prior to the public release of results. **However, we urge CMS to provide physicians with more time to review and appeal their results and to prohibit the release of results prior to appeal resolution, as described below. Specifically, we urge that CMS require qualified entities to provide reports to physicians and other providers/suppliers at least 90 business days prior to making the results public. Further, physicians and other providers/suppliers should be allowed at least 10**

business days to request data and at least an additional 30 business days to request an error correction.

As discussed earlier, we also strongly urge that CMS require qualified entities to make both Medicare data and private payer data available to the provider for their review prior to the public release of a quality performance report.

Unresolved Appeals and Resolution by an Independent Third Party

CMS proposes that qualified entities must make reports publicly available after a specified date (at a minimum 30 business days after sharing measure results with physicians and other providers/suppliers), regardless of the status of any physician or other provider/supplier request for error correction. Further, if a physician or other provider request for data or error correction is still outstanding at the time of making the reports public, the qualified entity must, if feasible, post publicly the name of the appealing provider and a description of the appeal request. **We oppose this proposal since it does not meet the statutory requirement that this process occur prior to the public release of the reports.** Allowing public reports to include information that is under appeal undermines the appeal and correction process. Stakeholders that use the public reports will not be able to properly assess the value of the information in the public report, rendering it useless, or worse, resulting in erroneous conclusions about physicians or other providers/suppliers based on invalid data. This could result in harm to patients or other stakeholders and unnecessarily negatively impact a physician's reputation. It also removes any incentive for qualified entities to comply with appeals process deadlines since the entity would know it can make reports public without resolving potential inaccuracies.

In the event that resolution is not achieved between the qualified entity and the physician or other provider/supplier, we urge that CMS establish an appeals process through an independent third party or through a CMS fast-track administrative process that adheres to short timelines for quick, valid review and action.

Further, if an error correction request is still outstanding when results are due for public release, the qualified entity should only display the provider's name and indicate that the results are still pending. Adoption of the extended review/appeal timeframes that we recommend above should help ensure that appeals can be resolved prior to the deadline for the public display of data.

Qualified Entities

We urge CMS to ensure that qualified entities demonstrate significant prior experience in handling Medicare data, especially their ability to: (i) aggregate data; (ii) provide physicians and other providers/suppliers the opportunity to review the reports/information in a timely matter, and (iii) handle the data in a manner that is safe, protects patient privacy, has a clear focus on improving performance, and meets appropriate safeguards, including ensuring the validity, accuracy, and meaningfulness of the data and public reports.

CMS states in the proposed rule that applicants would be expected to demonstrate expertise and sustained experience regarding the criteria for organizational and governance capabilities set forth in the proposed rule. CMS further states that an applicant would be considered to have demonstrated expertise and sustained experience on these criteria if the applicant can show that it has been handling claims data and calculating performance measures for a period of at least three years. **We support the three-year threshold for qualified entities.** This level of familiarity with claims data and performance measures is critical for ensuring the validity and accuracy of physician and other provider evaluations. **We further urge CMS to establish more stringent requirements for demonstrating expertise and sustained experience. Deeming an applicant to have met the “expertise and sustained experience” requirement simply because it has been doing so for three years is not stringent enough. Applicants should also be able to show an effective track record, and CMS should assess any valid physician or other provider/supplier complaints against a company that is applying to be a qualified entity.**

CMS also plans to consider applicants with fewer years of experience in handling claims data and calculating performance measures, or with limited experience implementing and maintaining a process for providers of services and suppliers to request error correction if the applicant has sufficient experience in other areas. **We caution CMS against approving applicants that do not have extensive experience handling claims data and calculating performance measures as this may jeopardize the integrity of the program.** Handling claims data and calculating performance measures are very complex processes, and although public reporting has the capacity to improve health care quality and delivery, but if not done correctly, it can result in very serious unintended adverse consequences for patients, physicians, the Medicare program, and all other stakeholders. At the very least, CMS should describe in the final rule the “other areas” in greater detail and explain what criteria an applicant without sufficient claims or performance measure experience would need to meet to be eligible for consideration.

CMS also proposes to evaluate all applicants’ data analysis systems for the methodologies they use to perform provider attribution, risk adjustment, reliability testing, efficiency measurement, handling of outliers, and the creation of appropriate peer groups for measurement. We agree that CMS should thoroughly evaluate applicants’ methodologies in all of these areas as they are critical to the production of accurate, reliable and actionable information to the public and physicians. The proposed rule, however, does not provide any specific criteria or standards against which to measure these methodologies used by the applicants. **This is problematic because without standards or accepted methodologies to perform these tasks, it will be difficult for CMS to evaluate the ability of applicants to meet the criteria as a qualified entity, as established by section 10332. Efforts to ensure that such specific criteria are established are critical to the success of this Medicare data sharing program.**

Data Not Subject to Discovery or Admitted as Evidence in Legal Proceedings

Section 10332 requires that data released to a qualified entity cannot be subject to discovery or admitted as evidence in judicial or administrative proceedings without consent of the provider/supplier. **We agree with this provision, and urge CMS to**

implement this provision through the final rule since CMS did not address this in the proposed regulation.

Effective Date/Number of Years of Data

We recognize that the statutory effective date of section 10332 is January 1, 2012, yet this provision does not require CMS to provide standardized extracts of data for time periods prior to January 1, 2012. CMS, however, is proposing to provide qualified entities with the most recent three years of Medicare data available at the time the qualified entity is approved for participation in the program. If a qualified entity is approved for participation in 2012, CMS will provide data for calendar years 2008, 2009, and 2010. Thereafter, CMS will provide qualified entities with the most recent additional year of data on a yearly basis.

We urge CMS to ensure that qualified entities do not issue public reports that concern data generated for services furnished prior to January 1, 2012. Due to experience with new quality programs, such as the PQRS, we know that these types of programs, at their inception, are fraught with many glitches that may render public reports invalid. Therefore, CMS should proceed with caution and first work with qualified entities to iron out glitches before public reporting occurs. CMS, for example, could provide qualified entities with one year of data, from 2010, from which entities could develop reports that are provided on a confidential basis. This would allow time to iron out the inevitable glitches that will occur in a new program. After this process takes place, and any major glitches are resolved, qualified entities could begin public reporting for data generated as of 2012.

We also urge CMS to provide qualified entities that are approved for participation with two previous years of data, rather than three. This will help to ensure that public reports are based on recent data. The more timely the data, the more actionable it will be for stakeholders and public reports. Data that is too old loses its validity and usefulness. Under CMS' proposal, data from 2008, for example, would be used for public reports in 2012. This means public reports would be based on four-year old data. Much can change over a year in a physician's office – a physician may have begun participating in a new public or private quality incentive program, and the physician's office is located close to a new 55 and older senior community. Without a program focused on using the most recent data, the performance reports generated from this effort would be outdated and not helpful to stakeholders.

Use of Claims Data

In the proposed rule, CMS implements the statutory requirement that physicians and other providers/suppliers will be evaluated using administrative claims data only (from Medicare and other sources). We agree that the type of data used from all sources must be consistent. Yet, we urge CMS to require qualified entities to include an acknowledgement in their public reports of the inherent limitations in using claims data to measure performance.

Further, we strongly support the proposal to require applicants to supply claims data from two sources other than Medicare. In order for physicians' performance to be accurately measured and assessed, it is imperative that qualified entities use a sufficient sample size and diverse population in their evaluations.

Geographic Areas

We agree with CMS's proposal to limit the provision of Medicare data to a specific geographic area. No entity has the breadth of data required to be eligible to receive nationwide Medicare claims data.

Consistency of ACA Public Reporting Provisions

We urge CMS to ensure that public reporting under section 10332 is consistent with other public reporting provisions enacted under the ACA. Different reporting requirements would be confusing and administratively burdensome, especially if physicians have to report the same data to multiple entities, using different data collection techniques.

Further, the proposed rule indicates that reports will be generated at the physician level. We recommend that qualified entities also be able to create reports at the group practice level as well, when appropriate.

Impact on Physicians and Other Health Care Providers of Services and Suppliers

We believe that CMS is underestimating both the hourly costs and time involved for physicians and other providers to engage in the data release program. CMS estimates that providers will spend an average of five hours reviewing their performance reports and ten hours preparing appeals in cases where providers believe that their reports contain errors. **We urge CMS to increase these estimates when evaluating the impact of the program on providers. In particular, we believe that the time required for a physician to prepare an appeal will exceed ten hours in the majority of cases, if the time required to pull and review patient charts is taken into consideration.** CMS approximates the total hourly costs for physicians' offices to engage in reviewing and appealing performance reports to be \$41.10. This figure significantly underestimates the financial impact of the program. Although certain administrative tasks, such as pulling patient records, may be performed by non-physician office staff, much of the work of reviewing and appealing reports will involve a physician's own time, for which an hourly rate of \$41.10 represents a major undervaluation of physician labor.

The proposed rule also estimates that approximately 25 applicants will be approved as qualified entities. With this number of entities generating performance reports, it is very likely that a physician will have multiple performance reports publicly available. These reports may present different determinations about physician or supplier quality performance, depending on the risk-adjustment and attribution methods used, as well as the timeliness of claims data examined. **We urge CMS to clarify in the final rule how this program will address the issue of multiple, differing reports from various qualified entities.**

The undersigned organizations appreciate the opportunity to provide our views to CMS on these important matters, and we look forward to working with CMS to resolve the significant and vital issues raised in connection with implementing section 10332. Should you have questions about our comments, they can be directed to Jennifer Shevchek, Assistant Director, Federal Affairs for the American Medical Association. She can be reached at jennifer.shevchek@ama-assn.org or 202-789-4688.

Sincerely,

American Academy of Dermatology Association
American Academy of Family Physicians
American Academy of Home Care Physicians
American Association of Neurological Surgeons
American Academy of Neurology
American Academy of Ophthalmology
American College of Chest Physicians
American College of Emergency Physicians
American College of Osteopathic Family Physicians
American College of Physicians
American College of Radiology
American College of Rheumatology
American College of Surgeons
American Congress of Obstetricians and Gynecologists
American Medical Association
American Osteopathic Association
American Psychiatric Association
American Society for Gastrointestinal Endoscopy
American Society for Radiation Oncology
American Society of Cataract and Refractive Surgery
American Society of Nuclear Cardiology
American Society of Plastic Surgeons
American Urological Association
College of American Pathologists
Congress of Neurological Surgeons
Hearth Rhythm Society
Infectious Diseases Society of America
Joint Council of Allergy, Asthma and Immunology
Medical Group Management Association
Society for Cardiovascular Angiography and Interventions
Society for Vascular Surgery
Society of Critical Care Medicine
The Society of Thoracic Surgeons

Medical Association of the State of Alabama
Alaska State Medical Association
Arizona Medical Association
Arkansas Medical Society
California Medical Association

Colorado Medical Society
Connecticut State Medical Society
Medical Society of Delaware
Medical Society of the District of Columbia
Florida Medical Association Inc
Medical Association of Georgia
Hawaii Medical Association
Idaho Medical Association
Illinois State Medical Society
Indiana State Medical Association
Iowa Medical Society
Kansas Medical Society
Kentucky Medical Association
Maine Medical Association
MedChi, The Maryland State Medical Society
Massachusetts Medical Society
Michigan State Medical Society
Minnesota Medical Association
Mississippi State Medical Association
Missouri State Medical Association
Montana Medical Association
Nebraska Medical Association
Nevada State Medical Association
New Hampshire Medical Society
Medical Society of New Jersey
New Mexico Medical Society
Medical Society of the State of New York
North Carolina Medical Society
North Dakota Medical Association
Ohio State Medical Association
Oklahoma State Medical Association
Oregon Medical Association
Pennsylvania Medical Society
Rhode Island Medical Society
South Carolina Medical Association
South Dakota State Medical Association
Tennessee Medical Association
Texas Medical Association
Utah Medical Association
Vermont Medical Society
Medical Society of Virginia
Washington State Medical Association
West Virginia State Medical Association
Wyoming Medical Society